Women and opiate addiction: a european perspective

Authors:
Paolo Stocco
Juan José Llopis
Laura De Fazio
Françoise Facy
Evelyne Mariani
Thomas Legl
Madalena de Carvalho
Agurtzane Castillo
Montse Rebollida

Financed with the assistance of the
EUROPEAN COMMISSION

IREFREA

WOMEN AND OPIATE ADDICTION: A EUROPEAN PERSPECTIVE

Research Coordinators:
Paolo Stocco, Juan José Llopis Llácer

WOMEN AND OPIATE ADDICTION: A EUROPEAN PERSPECTIVE

Authors:
Paolo Stocco, Juan José Llopis Llácer, Laura De Fazio, Françoise Facy, Evelyne Mariani, Thomas Legl, Madalena de Carvalho Lourenço, Agurtzane Castillo, Montse Rebollida

Collaborators:
Horst Broemer, Myriam Rabaud, Marion Andry, Margarida Rangel Henriques, Lydia Rabuffetti, Ingrid Broemer

Translated by Christina Cawthra and Andrea Boyd

Financed with the assistance of the
EUROPEAN COMMISSION

This book and other IREFREA books can be downloaded in www.irefrea.org

© IREFREA

I.S.B.N.: 84-931947-2-7
D. Legal: V-2204-2002

Editor: IREFREA ESPAÑA
Rambla, 15, 2º, 3ª E
07003 Palma de Mallorca (ESPAÑA)
irefrea@irefrea.org

Print: MARTIN IMPRESORES, S.L. • Pintor Jover, 1 • 46013 Valencia

IREFREA

Irefrea is a professional European network founded in 1988 interested in the promotion and research of prevention of drug and other child and adolescent problems.

IREFREA books can be downloaded in *www.irefrea.org*

IREFREA National Networks

IREFREA AUSTRIA
Karl Bohrn
Linke Wienzeile 112/4
A-1060 Wien
AUSTRIA
E-mail: *irefrea@chello.at*

IREFREA GERMANY
Horst Broemer
Lepsiusstraße 76
D-12163 Berlin
Tel. 0049-30-79705350
Fax 0049-30-79705352
DEUTSCHLAND
E-mail: *irefrea.d@gmx.de*

IREFREA SPAIN
Amador Calafat, Montse Juan, Juan José Llopis
Rambla, 15 (2-3)
07003 Palma De Mallorca
ESPAÑA
E-mail: *irefrea@irefrea.org*
irefrea@correo.cop.es

IREFREA FRANCE
Gerard Broyer
Universite Lumiere Lyon 2
Institut de Psychologie
5, av. Pierre Mendes.
CP 11. 69976 Bron Cedex
FRANCE
E-mail: *broyer@univ-lyon2.fr*

IREFREA ITALIA
Paolo Stocco
C.T. VILLA RENATA
Via Orsera, 4
30126 Lido di Venezia
ITALIA
E-mail: *irefrea@villarenata.org*

IREFREA GREECE
Anna Kokkevi
President of OKANA
(Organization Against Drugs)
Associate Professor
Averof 21
104-33 ATHENS
E-mail: *president@okana.gr*

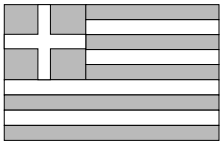
IREFREA PORTUGAL
Fernando Mendes
Urb. Construr Lote 6 (7-B)
Predio Bascal
3030 Coimbra
PORTUGAL
E-mail: *irefrea@esoterica.pt*

COLLABORATING PROFESSIONALS AND INSTITUTIONS

Prof. Francesco De Fazio
Laura De Fazio
Susanna Pietralunga
Patrizia Zavatti
ISTITUTO DI MEDICINA LEGALE
UNIVERSITA DI MODENA
Policlinico. Via del Pozzo, 71
41100 MODENA - ITALIA
E-mail: medlegmo@unimo.it

Prof. Goof Van De Wijngaart
Frank Leenders <leelee@wanadoo.nl>
UTRECHT UNIVERSITY
CVO ADDICTION RESEARCH INSTITUTE
Oudegracht 325
3511 PC Utrecht - HOLLAND
E-mail: addict@sw.ruu.nl

Prof. Mark Bellis. Head of Public Health
Karen Hughes-Research Associate
JOHN MOORE UNIVERSITY
Department of Public Health
School of Health and Human Sciences.
70 Great Crosshall St.
Liverpool. L3 2AB, UK
www.phslive.com



Prof. Kriistiina Kuussaari
UNIVERSITY OF TURKU
Department of Sociology 20014
Turku. Finland.
E-mail: liisa.kuussaari@utu.fi

AUTHORS AND CONTRIBUTORS

AUSTRIA

Thomas Legl

He works in the drug field for 20 years and is director of treatment at "Grüner Kreis", the most important facility for residential treatment of drug- addicts in Austria.

As psychologist he is specially engaged in the development of new programs as for double diagnosis, mothers and children and adolescents into the therapeutic setting.

Sports and adventure pedagogy in the mountain area is an other field of interest in his practical work.

He engages in national as international networking and research. Beneath his task as president of the Vienna NGO Committee on Narcotic Drugs he is board member of IREFREA Austria, EURO- TC (European Treatment Centres for Drug Addiction), ICAA (International Council on Alcohol and Addictions) and ARS (Addiction Research Society).

FRANCE

Marion Andry

Works as librarian for a researcher at the French National Medical Research Institute and is in charge of scientific bibliographic research covering the field of drug use. She also works as editorial secretary at HYGIENES, the official gazette of the French hospital infection society that publishes original articles in the field of hospital-acquired infection and related subjects.

Françoise Facy

Graduated from the University of Paris VI with a doctorate in mathematics on the analysis of attempted suicide in adolescence.

Project leader at the National Institute of Health and Medical Research (Inserm, France), she carries out research in epidemiology on studies of the use and misuse of psychotropic substances and their medical and social consequences.

She was also in charge of the network of public health research and an expert at the European Council (Pompidou Group). She took a part in the international epidemiological research of drug addicts. She collaborated on the following projects:

the analysis of drug addicts or alcoholics, concentrating on specialized care structures, as well as various forms of research on the precariousness process and the effects on the population's health.

Evelyne Mariani

She's a psychologist, graduate from Aix Marseille III, and she has works since 20 years in a specialized Service of public health, for the care for drug addicts in the Teaching Hospital of Nice, as Psychotherapist and Family systemic Therapist. She is also in charge of a class in the University of Nice Sophia-Antipolis.

Myriam Rabaud

Graduated from the University of Paris VI with a doctorate in cellular biology. She is a research engineer at the National Institute of Health and Medical Research (Inserm, France). She joined Françoise Facy's epidemiological team in 1995, and is currently studying psychotropic and assorted drug use among young adults.

GERMANY

Horst Broemer

Psychologist, director of Drogenhilfe Tannenhof Berlin.

Diploma in psychology about "Theory and Therapy of Drug Addiction", he has made a lot of researches: 1974-1975 Analysis of client data of a drug counselling center; 1975-1976 Developpment of a scientific concept for the analysis of a self help group; 1980 Research project in the USA: Intramurale Rehabilitation of Heroin Addicts; 1979-1982 Research project of TU-Drop (=Technical University of Berlin Drug Project); 1988-1990 Former clients of the Therapeutic Community Tannenhof: Interviews of former patients (Katamnesen von Therapieteilnehmern im Tannenhof); 1993 Prevention Connection Project Miami-Berlin. A hospitation in Miami, Florida (Miami Coalition for a Drugfree Community), 1992, 1993 Expert in Technical cooperation in Brasil, development of a new institutions for addicted families; research about family constellation work.

He engages in national and international networking, research, conferences and meetings: 1990 Development of EUROTC (European Conference of Therapeutic Communities), EUROTC 1990 in Berlin, EUROTC 1992 in Berlin, EUROTC 1996 Strasbourg, head organisation: RÜDLI (Switzerland).

1998 Technical Cooperation and Addiction: International Conference for Technical Cooperation, org. together with GTZ and FH-Koblenz, in Berlin 1998. Development of new programs for children with ADD/ADS.

Founder and President of IREFREA Germany; responsable researcher for IREFREA gender projects in Germany.

Ingrid Broemer

She is a psychologist and psychotherapist, Freie Universitaet Berlin, 1981 diploma and a training in Gestalttherapy, diploma 1985, Body therapy. Graduation as psychological psychotherapist in 1999, specialised in addiction therapy, trainer and supervisor. Lectures in university (FH Magdeburg).

Research IREFREA and Freie Universitaet Berlin.

ITALY

Laura De Fazio

She received her degree in law at the University of Modena and Reggio Emilia in 1986, research doctor in Criminal Science and Forensic Psychiatry, and winner of the prize "Premio Benigno Di Tullio" for the best scientific contribution in the field of criminology, published in the Italian Journal of Criminology in 1993-94. She has been a researcher at the University of Studies of Modena and Reggio Emilia since 1990 and is registered in the list of experts ex art. 80 L.354/75. In 1993-1994 she took part in the National Observatory on the phenomena of drug addictions, HIV and correlated syndromes, carried out by the Ministry of Justice (Head office Studies, Research, Legislation and Automation of the Department of penitentiary Administration), participating in the programming and actual carrying out of the research project.

She is an ordinary member of the Italian Society of Criminology, of the European Society of Criminology and of the Italian Society of Legal Medicine. She has published numerous works in the field of criminology.

Lydia Rabuffetti

Degree in Clinic Psychology at the University of Padua in 2001, collaborates for IREFREA ITALY.

Paolo Stocco

Degree in Clinic Psychology at the University of Padua in 1983, Master in Management of Drug addiction Services in 1990.

Agreed Professor, Prevention Methods and Prevention of Behaviour Pathology, at the post graduate School of Clinical Criminology, University of Modena.

President and Manager Director of Therapeutic Community of Villa Renata Venice. President of IREFREA ITALY.

PORTUGAL

Madalena de Carvalho Lourenço

She is Assistant Professor at the Faculty of Psychology and Educational Sciences, University of Coimbra, Portugal, UE. Her teaching area is Family Psychology and

Family Therapy, the Psychopathology of Childhood and Adolescence. Psychologist, Family and Couple Therapist (for the Portuguese Society of Family Therapy) is member of a Family Therapy Centre (NUSIAF) at the University of Coimbra.

Her theoretical and empirical interests include marital relationships, couple therapy, family and health, and prevention and treatment of drug addiction.

Margarida Rangel Henriques

Ph.D., is psychologist and Professor at the Faculty of Psychology and Educational Sciences, University of Porto, Portugal, UE. Her main interest is clinical psychology. She as developed an increasing work on formation, research and intervention with children, adolescents and families. To Margarida, narrative approaches have a outstanding place, especially on what concerned to the implications on psychopathology and psychotherapeutics interventions.

SPAIN

Agurtzane Castillo Aguilella

Psychologist, member of Irefrea Spain. Psychoterapist in the Teléfono de la Esperanza.

Juan José Llopis Llácer

Doctor in Psychiatry. Has a master in Drug addiction. Director of the «Unidad de Conductas Adictivas». Castellón (España).

Professor of Psychobiology of the "Universitat Jaume I de Castelló". Member of the «Junta Nacional de Socidrogalcohol». Member of the "Consejo Asesor en Prevención del Comisionado para la Droga del Gobierno Valenciano". Coordinator of Irefrea.

Montse Rebollida Gómez

Psychologist, expert on drug addiction. Psychotherapist for the association AVANT in Valencia. Member of *Socidrogalcohol.*

NEITHER THE COMMISSION, NOR ANY PERSON ACTING IN ITS NAME, IS RESPONSIBLE FOR THE USE THAT MIGHT BE MADE OF THE INFORMATION INCLUDED IN THIS DOCUMENT

INDEX

Pág.

PREFACE
Paolo Stocco 15

1. THE QUALITY OF DRUG ADDICTION IN WOMEN. ANALYSIS OF THE RESULTS OF THE IREFREA EUROPEAN STUDY "DRUG ADDICTION AND GENDER IDENTITY".
Juan José Llopis, Paolo Stocco, Agurtzane Castillo, Montse Rebollida 27

2. OPIATE ADDICTION: WHY IS THE FEMALE PERSPECTIVE NEGLECTED?
Evelyne Mariani 61

3. GENDER ORIENTED TREATMENT IN RESIDENTIAL LONG –TERM THERAPY.
Thomas Legl 77

4. WOMEN, PREGNANCY AND METHADONE TREATMENT.
Françoise Facy, Myriam Rabaud, Marion Andry 93

5. DRUGS, FEMALE CRIMINALITY AND DETENTION IN EUROPE.
Laura De Fazio 113

6. ADDICTION AND GENDER CONDITIONING. EFFECTS OF THE PERSONALITY VARIABLES.
Juan José Llopis Llácer, Montse Rebollida 127

7. THE COUPLE BEYOND THE CONSUMPTION
Madalena de Carvalho Lourenço, Margarida Rangel Henriques 175

PREFACE

By Paolo Stocco

When a reader opens a book for the first time, he or she awaits an explanation of the aims of the book and a brief summary of the contents of the various chapters. This is precisely what the following considerations aim to do.

The improvement of the situation of women

Over the last hundred years, the question of the improvement of the situation of women has taken on a prominent political meaning and has become one of the criteria used to measure the degree of a society's civil and democratic progress.

Strictly speaking, the policies of rights that are defined as the so-called equal opportunities – equal rights, equal duties and equal possibilities – should already be in the historic archives and regarded as fulfilled, at least in the so-called "mature" democracies.

However, this is not the case and the social and cultural delays and inertia continue their paths through numerous fields of knowledge and praxis.

Progress has been made to counter one of the most considerable and dramatic areas of sexual discrimination – violence perpetrated against women. In western democracies rights prefigure the achievement, at least in theory, of the equal rights of women, victims of violence and the men guilty of this crime.

Feminist reflection proposed a gender approach to violence against women that allowed the abolition of the old definitions of violence, the questioning of many of the certainties regarding female and male identity models, the redefinition of pertinent legislation, the development of research activities aimed at prevention as well as encouraging interventions in favour of women who have suffered violence (Bimbi et al, 2000).

Health - care and social - welfare policies

These results, or rather the diffusion of a culture with orientations of gender and equal opportunities have not yet been achieved in many sectors of health-care and social-welfare policies.

The number of the social-health-care services that propose gender-oriented interventions still appear to be extremely limited: indeed, in the majority of cases

services propose intervention protocols that are not differentiated according to gender and that underestimate women's needs (Irefrea, 2000).

In particular, in the field of the complex phenomena of drug addiction there is a widespread negligent attitude, which is dominated by the a-specificity of gender that is mirrored in the lack of studies and research. It suffices to mention that, at least in Europe, theorisations or research on addiction have been restricted to the outline of the male paths of evolution, without paying the least attention to the specific factors of the female population.

What is more, up to the end of the eighties, female drug addiction was considered a simple extension of male drug addiction – from certain aspects it is strange that in all the studies and research on substance abuse, with the exception of alcohol, such minor importance was given to the female condition and to the fact that under the epidemiological profile the prevalence and rate of female drug addicts is, and luckily remains lower than that of the males, so that all needs of welfare and the evolutionary potential were interpreted from a purely male point of view.

Inevitably, this was also reflected in the field of intervention and in the treatment policies where the symptoms of drug addiction are dominated by the identity of gender, leading to a dangerous cultural levelling out, a technicality that is ignored, sometimes denying the complexity of the problems and the questions involved. One of these fundamental questions is precisely that of the recognition of the differentiation of gender.

Equal opportunities for women so that they do not find themselves in a situation of psychosocial discomfort have been, and still are at the centre of discussion, but no mention is made of equal rights for women at risk, whether of a physical or psychological nature.

Therefore, according to which parameters can the current democracies be defined as civil and mature? Or, to be more precise, in which fields can civil and democratic progress of the community be measured?

It is certainly possible to measure it in many fields but not in those of public health-care and social-welfare policies, where all interventions only consider the needs and requirements of the male population.

Furthermore, the question naturally arises of what the limits of a welfare system are that is a-specific and undifferentiated according to gender?

What dangers are there in the approach and psychological intervention when the differences of gender are neutralised or, as is often the case, are masculinised?

In the field of social policies and the organisation of the treatment systems and arrangements, can the disregard of such differences lead the operators to a sort of short-sightedness or dangerous state of disinterest in the face of the dynamics of the expression of female discomfort?

And can the effectiveness of the psychological treatments be improved by interventions that are culturally oriented and that use a technical gender approach?

These and the other questions that could be formulated on this topic still remain open.

This book

Scientific literature is inadequate and the aim of this project is not to supply the answers but rather to contribute to the development of a debate in the field of public policies on health-care while paying particular attention to prevention and the treatment for drug addiction as part of the European programme of the fight against drugs.

The reader will therefore find various contributions including the preliminary results of a European research project carried out by IREFREA, that is part of a series of studies on the subject of female drug addictions that have been carried out by a group of researchers in different European countries over the last few years thanks to the precious support of the European Commission, DG SANCO.

The aim of these contributions is to highlight the complex situation of the woman who is either at risk or in circumstances of psychosocial discomfort due to drug abuse. The analysis of the complex phenomena of drug addiction will therefore be from a female point of view.

While aware of the limits of this work, the authors hope it will contribute to the development of a debate on the field of health-care policies with specific reference to the prevention and treatment for drug addiction.

We therefore hope that this book will lead to a greater understanding of the problematic of gender and that it may lead to ideas for further in-depth studies aimed at improving the quality of interventions and research activities, fields that need to respond to the needs of women with problems of drug addiction with increasing adequacy.

Differences of gender

Preliminarily, the question of gender identity is placed in a rather vast conceptual outline, starting with the primitive and natural biological differences that exist between the two sexes.

At both a biological and anatomic level is a difference corresponding to the terms “female and masculine”, that is perhaps, the matrix of all the different possibilities (Petrella, 2000).

The anatomical-physiological differences between a man and a woman are one of the constants and unshakeable polarisations that human beings have used to separate and divide them, with an indisputable priority over any other common quality and need such as willpower and common sense.

Primary witness to how important and unshakeable the sexual differentiation is can be found in the Old Testament of the Bible (The Bible, 1974).

By eating the fruit of the Tree of Knowledge, Adam and Eve realise they are naked and different from one another, thus symbolically ending an existence that had, until then, been purely vegetative and awaking the discriminating faculties of human gender.

In Genesis 3,7 one can read: *" And the eyes of them both were opened and they knew that they were naked; and they sewed fig leaves together and made themselves aprons"*.

Therefore, according to Genesis the first act of human awareness was an act of awareness of the differences of gender, and on which the successive history mankind was inscribed.

Each community reacted to the sexual differences by creating codes of behaviour, duties, roles, hierarchies or initiation rituals that play on or accentuate the natural dichotomy between the sexes (Sabatini, 1994).

Sexual dichotomy is probably one of the most intense and persistent efforts that society has taken upon itself to carry out, in all forms, at all times, consciously or unconsciously.

The deviation with which it was conceived is expressed in all cultures. Indeed, each human group has elaborated its own way of representing the mechanisms of determining the sex of the unborn child, the difference between male and female and the way in which gender should be constructed.

Interesting examples of how gender is an important element for the construction of social identity are also to be found in anthropological literature (Aa. Vv., 2000).

For numerous Somalian populations, genital mutilation (GM) is an obligatory passage for the construction of female identity (Grassivaro Gallo, 2001).

According to traditions of the populations she belongs to, only when her genitals have been mutilated is the woman socially born.

In this case, GM is part of the passage from an undifferentiated state to a precise social role in which "biology" is perfected by means of an initiation rite.

For these ethnic groups the social construction of identity is therefore carried out by a rite that marks the passage from infant to adult and the belonging to a sexual gender in a precise manner.

Indeed, GM is particularly widespread in all ethnic groups in which the sexes are rigorously separated and identity is constructed around a category of gender.

Within our culture the differentiation according to gender is also one of the foremost, strongest and pervasive pressures on the unborn child. Even before the child is given a name or physically separated from its mother, it is a girl or boy (Sabatini, 1994).

Although belonging to a gender is in itself a binding destiny, examples can be seen of how sexuality expresses itself in forms that evade the male-female dualism in psychological and anthropological literature, in mythology and even in biology.

A century ago in his work on the formation of personality, S. Freud wrote that although anatomy is destiny, sexual gender does not coincide *ipso facto* with the corresponding sexual identity (Petrella, 2000). During the therapeutic relationship, the psychoanalyst has the possibility to observe how the deviation between the anatomic sex and the experienced and imagined sex is expressed.

Confirmation of S. Freud's hypotheses is the phenomena of homosexuality, which, in its universality and historicity, has constantly questioned the specious linearity of the sexual bi-polarity (Sabatini, 1994).

Bisexuality is another phenomenon that has always accompanied the history of mankind, even characterising anatomy and physiology of pre-natal development.

Finally, transexuality decisively broke the sexual dualism by considering the question of gender identity a subjective choice rather than an unconditioned fate.

The complexity of these phenomena has shown that there are neither universal laws nor automatic correspondence between sexual gender and object choice between the sexual objectives and the modes of being.

As O. Weininger wrote, male and female, "absolute" man and woman are ideals, useful abstract notions as models, embodied and incarnated by nobody perfectly.

However, real people incarnate a continuation of intermediary forms, place of a measureless subjective range.

Apart from genital coupling and the procreative function, there is nothing that the two sexes could not exchange without achieving identical results. Indeed, there is no activity, role or function that, in itself, does not depend on which gender it belongs to.

Strictly speaking, one could be classified a male based on the external genital morphology, a female according to the chromosome karyotype, a male based on the social roles assumed and a female according to the object choice made, and so on.

The bio-physiological differences, while creating a predisposition, a conditioning, are formed in closely subjective and individual shapes, and their effects combine with a multitude of factors such as their educational models, relationships with relatives, social customs, the values chosen and personal experiences.

Furthermore, by treating the influence of the sexual hormones on the brains, neuroscience has also shown in structural and hormonal terms that very differentiated predispositions exist, but it is only with a specific combination of a strong social and cultural reinforcement that such differences take on the importance and meaning that we all know (Kandel, 1988).

Although anthropology has confirmed the absence of culture and human groups that have not defined the modes of being and feeling according to the sexes, it has also

highlighted the extreme relativity of what can be considered male and female (Sabatini, 1994).

Indeed, it is not possible to define what is female and male once and for all, since it depends on the system of values and definitions each group and community refers to.

Mythology also offers interesting examples of how the differences of gender evade the bi-polar mould, male –female.

Since ancient times myths have always opposed the specious linearity of dualism with the idea of original androgyny. We can find the most famous examples of original androgyny in the myth of creation in the Bible and in Plato's *Banquet*.

Genesis 1,27 says: "*God created man in his own image, in the image of God created he him; male and female created them"*, and then later in the New Testament, in the first reading to the Corinthians in 11,11 one can read: *"nevertheless, neither is the man without the woman, neither the woman without the man, in the Lord"* (The Bible, 1974).

Therefore, created in the image and likeness of God, man has both female and male characteristics.

The myth told by Aristophanes in his work says that "at the beginning there were three types of man, not two as now, the male, the female: there was a third, that had characteristics of the other two, in both physical appearance and name, but today all that remains is the name: the androgyne" (Platone, 2001).

"*There were three sexes because the male originated from the sun, the female from the earth and the other, with characteristics of the other two, from the moon"*

Worried by the limitless arrogance of man, Zeus decided to divide the human creature in two to make it weaker.

"*Once the human nature had been divided in two, each half desired the other, they went towards one another, embraced ….. letting themselves die of hunger since they no longer wanted to do anything alone".*

"Therefore, since ancient times man has had an innate reciprocal love that leads him back to his origins and that makes two beings one, thus restoring human nature."

In terms of chromosomes, even biology does not offer univocal solutions for masculinity and femininity (Luria, 1984).

Sexual differentiation therefore expresses itself in very individual forms that question the model of the male-female dualism (Sabatini, 1994).

This individual variety has, however, also been subject to a strong social and cultural pressure, that tries to limit personal diversification and to homogenise and normalise behaviour, censoring and stigmatising those that do not conform.

In their complexity, differences of gender are the basic requisite and condition that shape the structure of each culture without exhausting it completely.

The history of civilisation has been permeated with the accentuation of the differentiation of gender, albeit to various degrees and with great differences in quality between one culture and another: in any group, differences of gender can be noticed immediately in the language, varying from names and grammatical genders.

In numerous languages even the social position of the female is specified, differentiating the *status* of Mistress and Miss, a differentiation that is not made for the male gender.

These brief considerations allow us to underline how gender is one of the strongest and most pervasive elements that characterise us as a species, and this also has profound repercussions in the field of psychology.

The forms of expression of female discomfort

Female discomfort presents specific forms of expression that make it different from that of the male.

The specificity of the forms of expression of female discomfort lead to the connotation of the difference of gender as an important variable, also in psychopathology.

In the last century, during the times of S. Freud, women showed their discomfort with hysteria whereas today alimentary disorders, the abuse of psycho-pharmaceutical products and alcohol are much more widespread amongst women than men.

The phenomena of female drug addiction also presents a series of characteristics that appear to characterise her from a specific point of view compared to the male.

Studies have revealed the existence of particular psychological contexts and mechanisms that are linked to the first consumption, the degree of awareness regarding the decision taken and how they got hold of the money (Aa. Vv., 1999).

As regards the very first consumption of drugs and the formation of a sort of physical and psychological dependence on drugs, the partner and close family are of fundamental importance.

The first consumption usually takes place with a partner who is already addicted, perhaps inside a car: at the bottom of the motivations of these girls it appears is the curiosity of experiencing the same sensations as their partner, or the wish to identify with him even more.

These girls clearly appear undefended, not only because of their age but also because of a situation of discomfort in the family.

The model of identification that seems to have failed the most is that of the mother: the experiences of these women reveal two types of maternal figures: that of a mother who submits to an authoritarian and/or violent husband, or an aggressive, withdrawn mother.

Once they have started, the experience of drug addiction evolves differently according to the financial means available.

Prostitution is one of the most widespread means to obtain the money, making the female condition even more devastating and risky: when a problem of addiction appears, the woman finds herself in an even more vulnerable condition and exposed to greater risks for her physical health than is the case for the male drug addict.

The situation becomes even more complex in the case of mother drug addicts, who also have the responsibilities of the parent role.

Over the last few years, not only has there been an increase in the number of female drug addicts but also an increase in the cases of maternity under conditions of risk, in turn made worse by the emergence of the phenomena AIDS.

A further characteristic of the female population is that of alimentary disorders: while there is a low prevalence of female drug addicts compared to men, there is a noticeable prevalence of female drug addicts with alimentary disorders.

The differences of gender therefore suggest the existence of a connection between the field of alimentary disorders and drug addiction.

Finally, there are numerous drug-addicted patients with a double psychiatric diagnosis (with a clear prevalence of the depressive forms of bi-polar disorders) and this often adds to the increasing isolation of these women by both society and their families.

Despite the fact that studies have highlighted these characteristics of the expression of female discomfort, in nearly all cases health-care and social-welfare policies continue to propose forms of intervention that are not differentiated according to gender, thus underestimating the needs of the women and interpreting the evolutionary potential from a purely male point of view (Irefrea, 2000).

A further limitation of the current social-welfare policies is the scarce investment in gender research.

It is difficult to define which research is of more use, however it is possible to say that there are no funds and not the least attention is being paid to research on drug addiction and gender differences.

Over the last few years, the elements that involved the politics of study and prevention in the field of drug addiction were those linked to physical violation, sexual behaviour and the transmission of disease.

Little interest was paid to the studies on the construction of the female identity that took into consideration the most important experiences of both the childhood and adolescence of these women and the mechanisms of reconstruction of their own past.

One of the consequences of the limited development of studies on gender is that welfare activities continue to be based on ideological orientations that have not proved efficient. On the contrary, the contrasting policies of the phenomena of drug addiction

should be based on data that has been verified, on detailed knowledge and not on generic statements of a moralistic or ideological nature.

Development of the studies on the difference of gender would not only be useful for the orientation of intervention policies and for the definition of accurate intervention aims but would also increase the quality and effectiveness of the results.

Furthermore, in any field knowledge is an indispensable element that allows an understanding of the nature, the dimensions, the evolution and the motivations (if present) underlying a phenomenon (Sabatini, 1994).

Whatever the form of research, whether anthropological, psychological, social, epidemiological or clinical, it is the main instrument to obtain knowledge since it allows:

- an understanding of the dimensions, characteristics, evolution over time and the geographical distribution of a phenomena;
- the development of knowledge of the biological, psychological, anthropological, financial and social aspects that underlie the conditions of development of a phenomena;
- the development and diffusion of new methodologies of monitoring phenomena;
- the highlighting of predisposed and protective factors when faced with a given situation;
- a greater effectiveness of the interventions, preventive measures, treatment or rehabilitation.

Research, just like activities of intervention, prevention, treatment and psycho-social rehabilitation is therefore an instrument that is of primary importance and in which it would be hoped that a much larger sum of money is invested.

In particular, in the field of female drug addiction, it would be hoped that:

- more studies are carried out on female drug addiction;
- new knowledge regarding the specificity of the female population is propagated;
- the number of services with gender orientation proposing individualised intervention programmes is increased.

The creation of instruments of prevention and specific approach and intervention would be a signal for the true achievement of equal opportunities – also for women in situations of discomfort, with the consequence of implementing contrasting policies based on precise knowledge, sound data and not on generic affirmations.

Finally, it would be opportune to consider the research, evaluation and intervention as closely linked units and not as separate entities.

In the field of drug addiction, due to the contemporary involvement of individual and social factors, the activities regarding information, evaluation and research are not able to supply an overall picture of the phenomena if separated.

Although they can be understood as separate entities, prevention, treatment, evaluation and research must be integrated to form a single, detailed mosaic to overcome the single visions of fragments that are often shortsighted and incomplete.

Summary of the chapters

The content of each chapter is summarised in the following paragraphs.

1. *The quality of drug addiction in women. Analysis of the results of the IREFREA European study "Drug Addiction and Gender Identity"*

   The first chapter of the book looks at a research project on female drug addicts carried out by IREFREA. The beginning of the chapter underlines how heroine addiction amongst women is a pathology which has had a low impact on research into drug addiction. In all probability, this scant scientific output is not due to a lack of interest on the part of researchers, but rather to the difficulty in compiling samples of sufficient scale to be able to study the incidence and characteristics of drug addiction amongst women with a minimum of representation. As a consequence, this lack of knowledge on the specific nature of certain characteristics of addiction in women has led to the spread of a general concept of the drug addict with a single profile, mistakenly accepted as the standard profile, which does not recognise gender differences.

2. *Opiate addiction: why is the female perspective neglected?*

   Drug addiction and its correlated problems are the result of multiple factors that affect the individual interactively. This chapter presents an overview of the relationship between female drug abusers and their family of origin, in order to propose some hypotheses on reasons why young girls and female abusers involve their families even less in the contact with or encouragement to attend counselling. These hypotheses must be based on the European literature on the position of female addicts within the family of origin, the type of relationship that she had with her parents and siblings as a child and as an adolescent and the role and position that drugs seem to have taken within the family set-up.

3. *Gender - oriented treatment in residential long - term therapy*

   The aim of this chapter is twofold: alongside providing a short overview of the state-of-affairs in European gender-oriented addiction treatment and more concretely putting these findings into the perspective of residential long-term therapy in a therapeutic community we are going to present the structure of an Austrian therapy institution with particular regard to the way in which gender-oriented approaches are being implemented in both gender-separating and gender-integrating settings. Moreover, and this forms the very core of this article, focus group studies were carried out among both male and female patients at the TC "Marienhof", trying to establish their responses and attitudes to gender-related issues in drug therapy.

4. Women, pregnancy and methadone treatment

In this charter, the subject of treatment is extended to the methadone treatment of women during pregnancy.

The author carries out a precise and accurate analysis of the evolution of methadone treatment in France, taking into consideration the social, family, legal and medical aspects that characterise the situation of female drug addicts during pregnancy who undergo substitutive treatment.

5. Drugs, female criminality and detention in Europe

If drug addiction represents a social problem, one of the fundamental aspects of this is the relationship between drugs and criminality.

The author's proposal of analysis begins by explaining the misunderstanding that drug addiction is equivalent to criminal behaviour. According to the author, it is drug abuse itself that leads to an extremely complex series of crimes.

In particular, apart from the specific elements that characterise female drug addictions and apart from the aspects highlighted by numerous authors concerning female delinquency, it should also be underlined how the relationship between drugs and criminality, while it does not completely differ from the terms outlined above, still recognises characteristics that are of considerable interest when, as often happens in the lives of many drug addicts, the female drug addict and perpetrator of a crime, not only experiences imprisonment but also has underage children.

6. Addiction and gender conditioning. Effects of the personality variables

The classical explanatory model of drug dependencies encompasses three already known factors: subject, drug and environment, and it is from their interaction that addiction will or will not develop, as will the seriousness and consequences of the same.

In this present text, we are carrying out an examination of the most notable theoretical aspects in relation to personality traits and drug addiction, and the methodological difficulties and practices for personality diagnosis in addicts, with special emphasis on antisocial traits, post-traumatic stress, depression and sensation-seeking behaviours. In the second section of the work, we set out the results of a comparative study of personality traits, measured with the Mini-Mult Test, on a sample of women addicted to opiates, and the traits of a second sample of male heroin addicts, and a control group comprising women with no addictive and/or psychiatric pathology. Finally, we present the data on the evolution of the personality traits of the two samples of addicts, with test-retest evaluation at commencement of treatment and at a two-year follow-up.

7. The couple beyond the consumption

This chapter draws attention to the couple, understood both as a source of resilience and as a source of maintenance of malfunctioning and diverse

symptomatology. The author states that «to understand how the individual symptomatology can be part of the circular game of the multiple complex and permanent interactions of the married couple is a very interesting challenge». The behaviour is only understandable in the surrounding situation and where the conjugality plays a relevant role. Without forgetting the individual vulnerabilities (physical and psychological), the nature of the conjugal system must be evaluated in order to understand the function of the symptom / pathology, namely drug abuse.

References

Aa.Vv. (1999) *Tossicodipendenze. Relazione annuale al parlamento sullo stato delle tossicodipendenze in Italia 1999.* Presidenza del Consiglio dei Ministri, Dipartimento per gli Affari Sociali, Italy.

Aa.Vv. (2000) *Senza le ali. Le mutilazioni genitali femminili.* FrancoAngeli, Milano, Italy.

Bimbi et al (2000) *Libertà femminile e violenza sulle donne. Strumenti di lavoro per interventi con orientamenti di genere.* FrancoAngeli, Milano, Italy.

Grassivaro Gallo P. Rabuffetti L. Viviani F. (2001) *Sunna Gudnin. An Alternative Ritual to Infibulation in Merka Somalia.* In: Understanding Circumcision. A Multi – Disciplinary Approach to a Multi – Dimension Problem, Klower Academic / Plenum Publishers.

Irefrea & European Commision (2000) *Women Drug Abuse in Europe: Gender Identity.* Martin Impresores, Valencia, Spain.

Kandel E. R. Schwartz J. H. Jessel T. M. (1988) *Principi di neuroscienze.* Casa Editrice Ambrosiana, Milano, Italy.

Luria S. E. Gould S. J. Singer S. (1984) *Una visione della vita. Introduzione alla biologia.* Zanichelli, Bologna, Italy.

Platone (2001) *Convito.* Gazanti Libri, Prato, Italy.

Petrella F. (2000) *Atti del convegno Femminile e Maschile: dall'identità di genere alla persona*. Italy.

Sabatini R. (1994) *L'astuzia del desiderio.* Editoroma, Roma, Italy.

The Bible (1974) Edizioni Dehoniane, Bologna, Italy.

1. THE QUALITY OF DRUG ADDICTION IN WOMEN. ANALYSIS OF THE RESULTS OF THE IREFREA EUROPEAN STUDY "DRUG ADDICTION AND GENDER IDENTITY"

By Juan José Llopis, Paolo Stocco, Agurtzane Castillo, Montse Rebollida

Introduction

Heroin addiction amongst women is a pathology which has had a low impact on research into drug addiction. In all probability, this scant scientific output is not due to a lack of interest on the part of researchers, but rather to the difficulty in compiling samples of sufficient scale to be able to study the incidence and characteristics of drug addiction amongst women with a minimum of representation.

The most frequently studied groups have been clinical populations of both sexes, where men predominate and the representation of women is so low that data on them is lost in the intricate procedures of statistical analysis of variables, with the final result that dismissed as being statistically insignificant.

As a consequence, this lack of knowledge on the specific nature of certain characteristics of addiction in women has led to the spread of a general concept of the drug addict with a single profile, mistakenly accepted as the standard profile, which does not recognise gender differences. In most cases, data referring to women has to be extrapolated from published studies on mixed populations.

The mere interpretation of statistical data, very often from samples with scarce representation, gives only a partial knowledge of the reality facing the female drug addict. A lifestyle, an attitude and a series of beliefs tend to be hidden behind the cold statistics, which must be clarified in order to reach an understanding of the everyday reality of the female heroin addict.

Since 1998, the European network IREFREA has been carrying out gender based studies with the aim of discovering the characteristics of the European woman addict, from both a quantitative and a qualitative perspective. Fundamentally, we have analysed women opiate, preferably heroin, addicts, from five countries, basing our study on data from the European Drug Observatory which indicates this to be the main addiction in individuals seeking drug addiction treatment in Europe as a whole, with percentages ranging from 50% to 70% depending on the country. As in our studies, patients requesting treatment are users of more than one drug (OEDT 01) and thus we are dealing with polydrug addicts whose main drug consumption is heroin.

Methodology

In the first phase, studies were carried out in five countries, namely Italy, Spain, Germany, France and Portugal, with the subsequent incorporation of Austria. However, due

to its later incorporation, data on this country is not presented here. The first part of the study was an extensive interview of 340 female polydrug addicts, principally diagnosed as heroin addicts, who had requested treatment in the five above-mentioned countries. A naturalistic descriptive study was designed, with respondents chosen at random.

The interview was carried out by means of an ad hoc questionnaire which alternated closed response variables with open response questions classified within the following areas: education, employment, drug use and addiction, emotional and sexual, motherhood, legal, physical health, therapy, family and finally, a section which gathered descriptive data on the respondent such as age, marital status, diagnosis etc.

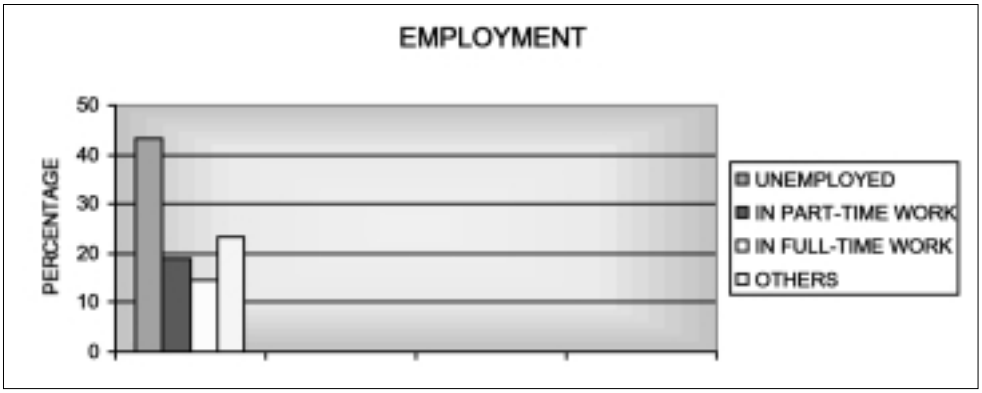
Analysis of the statistical data enabled us to highlight certain variables as being more significant, which we have called dimensions. During the second year of the research, our target was to investigate, by means of qualitative procedures, the importance of these particular dimensions by bringing up these data again within focus groups in which the addicts freely expressed their experiences of and opinions on the statistical results.

This publication, following on from these procedures, presents the most significant socio-demographic and drug use data, with particular attention to the interpersonal relationships related to the addiction and its consequences, classified by dimensions. At the same time, an analysis is made of the opinions expressed by the women, both in open interviews and focus groups, referring to the dimensions which form key points in the development of their drug addiction, and which qualitatively illustrate the quantitative results.

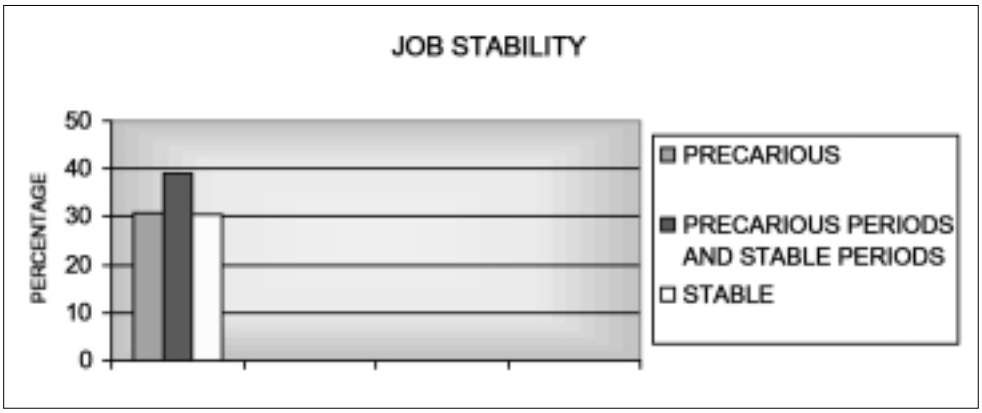
Results

The employment dimension

Practically all the women interviewed have worked since they finished studying. They are normally in low skilled jobs (23,26 % work as cleaners, waitresses or delivering publicity) mainly with temporary contracts or with no contract. At the time of the interview, 43.2% were unemployed.



A decline in the type of work and in professional category is frequently found, to the extent that prostitution is at times resorted to. Some 38.98% alternate periods of work with periods of unemployment and 30.67% consider the stability of their employment to be highly precarious.



> "At 13, I started in a cake shop, then as a domestic cleaner without a contract, nine years as a housewife and since then, prostitution" (Mother, 36).
>
> "I started off as a secretary, then as a waitress in a restaurant, after that in a cleaning firm with no contract, and finally delivering publicity. I haven't worked for two years" (No children, 32).

Although very few cases of steady, skilled employment were found, women who spontaneously consider their employment situation to be precarious are a minority. This belief is heavily influenced by the pessimistic view of the future brought about by their drug addiction, whose repercussions on their employment situation are accepted.

> "My drug addiction has influenced my lack of aspirations and I've missed chances to work and I haven't looked for a job because my addiction came first" (Mother, 24).
>
> "I had a steady job until I started taking heroin at 26, in spite of my heavy drinking. After that, everything went wrong. I wasn't doing my job properly, to the point that the firm found out I was using drugs, and while I was off work they sent me a letter recommending me to leave... we came to an agreement and they advised me not to come back for the job" (Mother 30).

The addiction itself has been a determinant in the employment situation of 73% of those interviewed who replied to this question.

> "When you are a drug addict, it is almost impossible to keep a job".
>
> "In realty I have always had problems with work: they got worse with the drug addiction because I was more unstable and if I wasn't well, I couldn't work".

"If I had some money, I used to spend it on drugs, I would get to work late, and in the end I would leave before they could sack me. Then I would look for another which would be worse and with less money..." (Mother, 32).

In some cases, this is stressed even more in that physical deterioration, a consequence of the addiction, leads to discrimination in the job market, thereby propagating the social stereotype that job opportunities for women are related to their attractiveness.

"If you look physically run down, even if you don't take drugs any more, they don't believe you and they don't give you the job. It's another thing if you've got a good body, like you, even if you're on drugs..." (In a relationship, no children).

"…I went into hospital because I had hepatites C, and when my employers found out, I decided to resign".

The majority (77%), agree that the discrimination at work they have either experienced personally or observed in cases of female colleagues is no more than a reproduction of the socially accepted models related to gender, a point which some international studies have already indicated (Jang, Livesley and Vernon, 97).

"People look down on a woman who gets drunk or uses drugs... I work with a man in the kitchen who's a heroin addict. Everyone knows and nobody says anything... but if I go to the toilet twice, they pull me up for it. Why? Because he's a man and I'm a woman" (Married, one child).

"For a female drug addict it is more difficult because they judge you, they think you are a prostitute – it's terrible. I remember my colleagues talking about me behind my back when I worked".

"It's true. It's much more of a scandal for a woman. Where I come from a man can do whatever he wants, but if you are a woman and a drug addict they all point at you, they look at you differently".

"I think that a female drug addict is regarded as a greater selling-off, both physical and moral".

It should be pointed ou that these opinions corroborate general population poll results which show that working women's earnings may be between 1800 and 6000 euros less per year than men's, depending on the country in question.

The same situation is found when the aspirations of the women interviewed are evaluated, or whether they have felt satisfied in their jobs. They specify their aspirations as having a steady job and not facing discrimination as women.

"I liked what I did in the catering sector, not in the brothel... I'd like to have the chance to go back to a normal job" (No children, 25).

"... just give me the same opportunities and treat me the same as the men" (No children, 26).

Employment tends to be minimal or non-existent, and the women's financial situation is based on a relationship of dependency with either their parents or their partner for maintenance, or comes in the form of sickness benefit, usually for HIV, or from public charity. This situation is really nothing more than an extension of the lifestyle they had during their active addiction period, thereby continuing to maintain an attitude of submission which once again puts the woman in a situation where she is dependent on others.

"I don't have a job. I live off sickness benefit. My financial situation is rock bottom; I live off what I'm given. We go to eat in a ready-made food place where a woman gives us the leftovers... I don't worry about money, as long as I can eat and sleep.... but affection... now I don't have any" (Cristina).

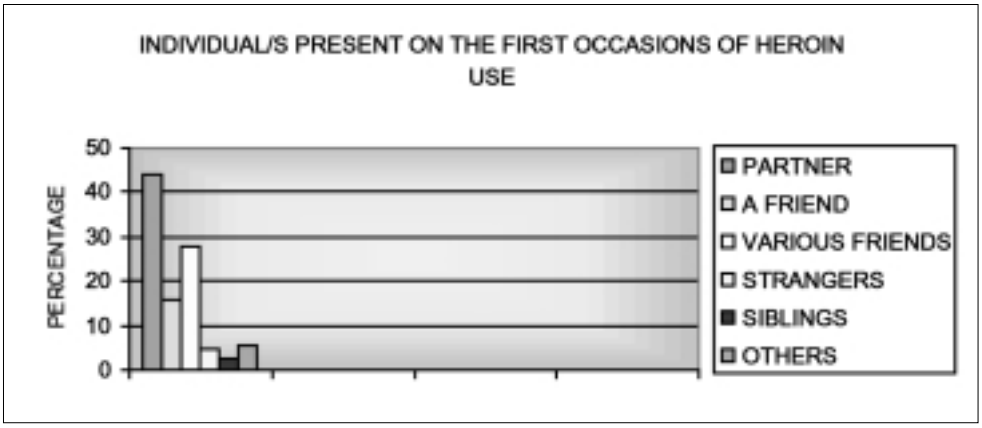
Various authors (NIDA 94, Allen 94, Spiral 95, Llopis 97, Navarro 00) all report lower professional skill, higher unemployment rates and greater difficulty in achieving economic independence in women addicts than in men.

Drugs

The **First Occasions of Heroin Use** take place, in most cases, with a boyfriend or husband (43%). His participation is decisive as an instigator or in the modification of the woman's attitude towards drugs, and even in some cases as an "administrator" of the first dispensation of heroin to the woman.

"My husband had been dealing heroin for some time, and it was always around. That's what made me decide to try it" (Mother, 36).

"My boyfriend used drugs. He was from an upper class army family, so I then saw drugs as being acceptable. I had always considered it to be a deviant activity, but then I started to see it as normal, that made people feel good, and I decided to try it". (Mother, 32).



"... getting to go out with him had been a big effort and I didn't want to lose him. He used drugs and to make our relationship closer, I couldn't see any alternative but to take them too. I was also convinced that I could take heroin when I wanted, that I was going to keep it under control... but I was wrong" (No children, 29).

"I started taking drugs because I wanted to know how it made him feel".

"It was something I didn't know and I wanted to get to know it through him".

"When I first saw my partner I was really curious about the effects heroine can have".

"In a way I was angry….may be I was also sort of jealous of his relationship with drugs and I wanted to be part of it, too, I didn't want to be excluded so I wanted to try it".

In a 1996 study by the Spanish Institute for Women "*Mujer y drogas" ("Women and Drugs")*, as in the 1994 NIDA report, special emphasis is given to the addicted partner factor. It considers that "many women heroin addicts start taking the drug through their partner, to feel closer to him or her, or because they feel under pressure to also share the experience". In 1997, Llopis stated that, in contrast to men, women's initial use of heroin is influenced by men, particularly by a sexual partner who is very often a heroin addict. Lye and Waldron (98) also coincide on this issue when they point out that in both sexes, high levels of drug use are significantly linked to deviant attitudes to living together and to the family.

Against this initial favourable attitude on the part of the male partner, a paradox later occurs when he wants her to stop using the drug, arguing that he does not want her to become addicted. This opposition to her drug use does not usually solve anything.

"The time came when he saw that I could get hooked, because although I constantly asked him to give me (heroin) he wouldn't, so I started getting it elsewhere" (Married, one child*)*.

"...yes, but you get really stubborn. I want you to give me some, if you're taking it, I am too" (Separated, no children).

Some of the women interviewed identified the imitation of other drug users as a factor in their initiation (21.7%), although it should be pointed out that they were not in a relationship at that moment.

"Using drugs gave me a sense of belonging..".

It is interesting to note that when references are made to the **Most Difficult Moment in Course of their Drug Use** the women do not speak of prison or physical illness, abuse, etc., but rather of the moment when they realise they are addicted, the moment when "everything falls to pieces".

"When I saw that I needed to take it whatever, I saw how degraded I was, that any control was out of my hands" (Mother, 38).

"When I was hooked on heroin and my partner had to inject me, I was totally dependent on him and on the drug" (Mother, 32).

"I dealt and snorted at first. My husband was hooked, but he didn't realise that I was taking it too. He sometimes offered me some but he didn't want me to take it every day... I didn't know anything. One night when I slept at my parents house I didn't know what was happening to me. In the morning I snorted some and felt better, and it was then that I thought, My god!" (Ana).

This relationship of dependency on the addicted partner, both in the emotional context and as the supplier of the drug, keeps the woman in the state of ignorance and unawareness we have seen here, and leads her into a situation where she is powerless to tackle her problem once the relationship comes to an end. According to a study by the Fundación Spiral (95) the existence of this double dependency on the part of the woman is basic to the development of the addiction and to the resumption of her use of the drug.

"The worst moment came when I had to decide between my boyfriend (drug addict) and my family... I stayed with him" (No children, 25).

"When my husband was sent to prison. He had been dealing, and it was then that I thought I had *cold turkey*. This made me realize I was addicted... I was 17 and I realized that while I was with him, I had everything I needed, but when they sent him down, I had nothing... At that time I didn't know anything... he injected me" (Clara).

In this study, we have observed how the appearance of the **Abstinence Syndrome**, regardless of the circumstances that bring it on, is what mainly opens the woman's eyes to her addiction, and induces her to start to think about looking for help.

"I realised when I got up one day and I couldn't operate... well no, I was looking out for myself then... I looked for help when my emotional support broke down, when I could see the affection disappearing and I was losing the relationship..."(Gracia).

"What made me stop was the sight of my partner's physical condition" (age not given, French).

What the addict really sees as a crucial need is the **Psychological Support** to get over the dependency, a need which is not usually effectively met by treatment centres.

> "There's a lot of deception in this. In one centre I was in, we spent the day making stickers and Aids ribbons and then they sent you out to some traffic lights or the market to ask for money. I needed psychological help, not that" (Cristina).

> "That's the worst. The cold turkey is the easiest bit, what's difficult is to get through what comes after without taking anything" (María).

Previous treatments were unsuccessful because "I had no psychological support" (34 years old, not in treatment, Italian).

> "You don't just have to have the structures, but also people close to you"(30 years old, Italian).

> "You have to have permanent support from your family, friends and therapists" (age not given, French).

The ambiguity of wanting and not wanting, the need to stop taking the drug and the pathological desire characteristic of the psychological dependency, end up getting confused in the first attempts at treatment and lead to serious discordance between the supply of and demand for therapy, which is of no benefit whatsoever to the addict.

> "I've been in out-patient treatment three times and it's always been the same, I went back to it... to the point where my mother threw me out of the house because I was in a Centre and as it didn't work, they told my mother to put me on the streets... I slept for a year in a factory. Putting you out on the street doesn't help you, I needed just the opposite... support" (Sandra).

The abstinence syndrome, the need for psychological treatment and emotional support together the lack of information during the first years of addiction are key elements which obstruct the search for help and the effectiveness of the attention received.

> "I can't cope with complete abstinence" (age not given, French).

> "Sometimes the lack of motivation towards life, or the lack of will power makes it impossible for me to bear the days of abstinence" (27 years old, Portuguese).

Previous treatments failed because "I had no psychological support" (not in treatment, 38 years old, Italian).

> "I have never had any support (in treatment, 37 years old, Italian).

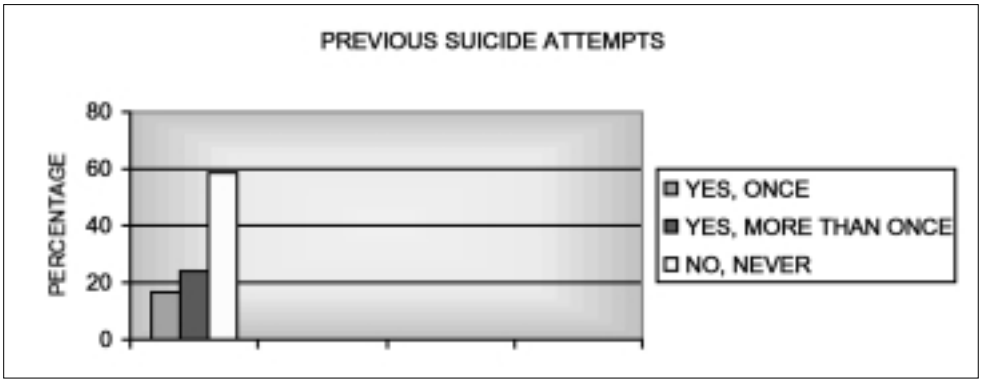
> "Nobody told me I needed it" (age not given, French).

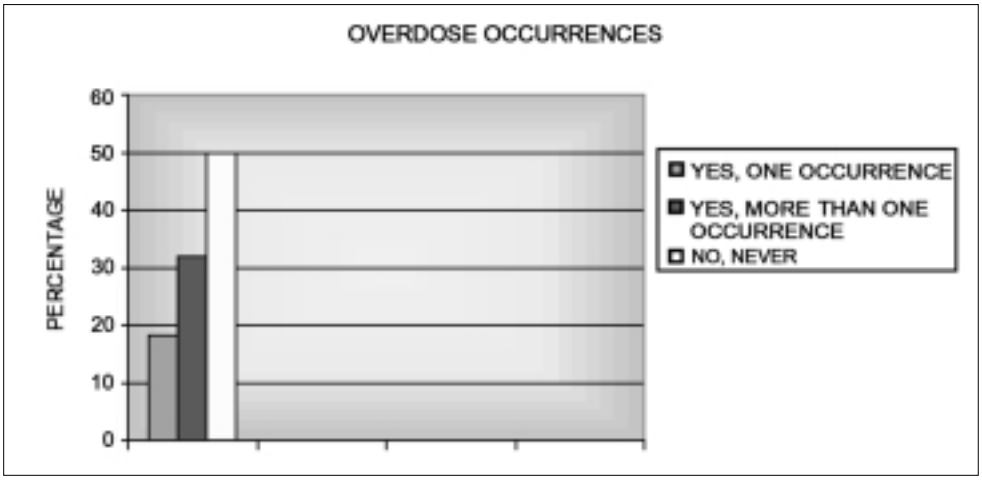
> "I didn't realise I was addicted to cocaine" (age not given, French).

> "I haven't heard of treatments or treatment centres" (age not given, French).

Overdose and Suicide Attempts (50% and 41% respectively) referred to are closely linked due to the frequency in which the addicted women use overdose as a way of committing suicide. On other occasions, the overdose is accidental, caused by the fact that it is the woman's partner who injects the drug. Thus, multiple overdoses tend to be frequent (24%).

According to the European Drug Observatory, the prevalence of overdose deaths in different countries is difficult to evaluate as the definitions of overdose and the registration procedures are governed by different criteria. However, they point out that various substances such as benzodiazepines and alcohol are often found, but that opiates are still present in nearly all overdose deaths, with Greece, Germany, Ireland and Spain prominent in this aspect (OEDT 01). Many suicide attempts result from depression caused by the personal deterioration brought about by the addiction or by the conflictive nature of the relationship with either their partner or their family.





"… I remember that I didn't pay attention to anything, I no longer cared about anything. I only wished I would never wake up again".

"... I didn't want to go on living like this... I was in detoxification treatment, living with my addicted partner, out of work and mentally in a really bad state" (Mother, 27. Pills overdose at 21).

"To increase the effects, I took more than my body could take... in the street with other junkies, out of work and my partner in prison..." (Mother, 34).

"I mixed heroin and cocaine with my boyfriend and another friend, my boyfriend injected me and he gave me too much... in a cheap hotel we both passed out and the friend phoned for an ambulance" (No children, 28).

We consider that our data on suicide attempts must be stressed since, following the qualitative analysis through the focus groups, it proved relevant to the answers to the questionnaire given by the women addicts. In our opinion, this confirms the need for an in-depth qualitative analysis of the epidemiological data. The reason why we did not find any references to suicides amongst drug addicts in the bibliography reviewed could be precisely because of the practical absence of this type of study.

Motives for **Relapse include** the desire to use drugs, amongst the European women drug addicts we studied (52%), the **Psychological Dependence**. This is commonly known as anxiety and is often experienced from the outset of detoxification.

"I started using again because the desire was greater than anything else, even though I knew that I would get hooked again" (Mother, 35).

"The anxiety didn't go away, they took me off the tranquillisers and I went back onto the heroin at the first chance... no treatment worked for me, the desire to take it was always there" (No children, 28).

"I didn't follow the treatment properly, I only thought about heroine" (Age not given, French).

"Drugs are stronger than anything else" (33 years old, Portuguese).

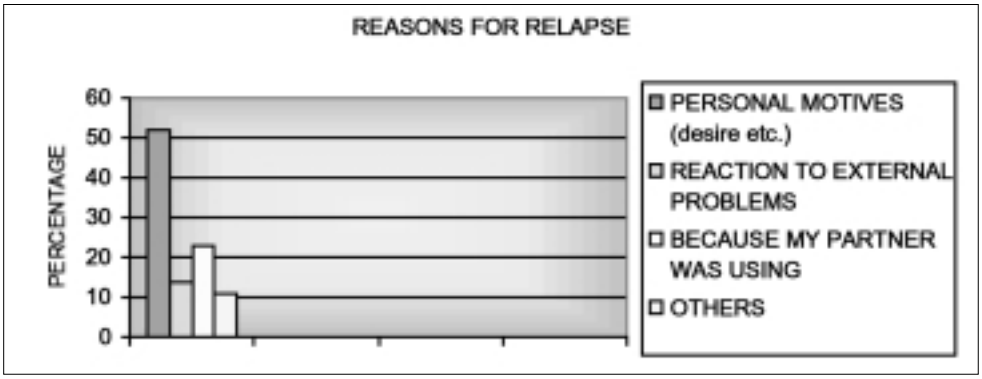
"Drug addiction is my character" (33 years old, German).

"Cocaine always makes me feel fine" (30 years old, Italian).

The **Influence of the Addicted Husband or Partner** is basic to the **Resumption of Use** of heroin in the female drug addict, according to the testimonies of 23% of the women responding to this item in the survey. The desire to create a closer bond, to help the partner to get off the habit or for self-destruction are the main determinants in female relapse (Palop 00).

"We were both in treatment and there was nobody controlling whether we took the naltrexone or not. He injected and so I did the same" (Mother, 32).

"I thought he was off it, but he wasn't. I went back with him and did the same..."(No children, 27).



In some cases, relapse seems to be caused by a state of depression, which occurs during the first stages of treatment for addiction.

> "Nothing had any point to it, I felt stressed out at work and depressed, what I was doing wasn't worth the effort..." (Mother, 30).
>
> "I need drugs to get over my depression" (In treatment, 38 years old, German).
>
> "I wasn't able to do it because I was depressed" (Not in treatment, 20 years old, Portuguese).
>
> "I felt terrible in my head" (Age not given, French).

The addicted women expressed the emptiness they felt once they had got over the abstinence symptomatology, thereby indirectly questioning the treatment programmes approached from a purely physical view of the addiction.

> "They took me to a clinic where they put you to sleep and then wake you up on the third day. But when I got back here, it was awful. I felt lonely, lost, that I was nobody, it was as though I had *junkie* tattooed on my forehead... I ended up using again"(Clara).

Previous treatments were unsuccessful "because I had to resolve the problem in greater depth" (in treatment, age not given, Italian).

> "The previous treatment failed because "I was not profound enough for my character" (29 years old, Austrian).
>
> "They gave me medicine that made me addicted" (35 years old, German).
>
> "When heroine had gone out of my head, Subutex became a prison" (age not given, French).
>
> "Subutex replaced heroine, I considered it to be my drug" (age not given, French).

The impotence felt on trying to get over the **Psychological Dependence** is patently obvious in that it leads once again to drug use to avoid feelings of "*being lost... alone...*"

This is another point which clearly defines the behaviour of addiction. What happens when withdrawal is overcome? The feelings of emptiness and strangeness towards their surrounding environment on giving up the drug places them in an enormous contradiction: they do not belong to the non-drug user environment but neither can they go back to the drug user environment. A lack of identity arises here, which is practically impossible to get over without good help and psychosocial intervention.

> "I was on a Proyecto Hombre reinsertion programme. When I went out with clean friends, I felt out of place, but I didn't talk about this at home, and I wasn't honest about it on the programme either. I had less and less self-esteem, and thought that people were only with me because they felt sorry for me. That was when I felt I was the same as the others, the other addicts, and I went back to them and started using again... it happened because I bottled it up and wasn't straight about it" (No children, 25).

> "I felt alone and ill at ease with myself" (36 years old Portuguese).

> "I felt completely empty, I was very sad and insecure" (in treatment, 28 years old, Portuguese).

> "For me it was the boredom and solitude, you have to have other interests and stimuli to get you out" (in treatment, 26 years old, Italian).

Women addicts go back to drug use as a reaction, or an answer, to this essential strangeness. They are looking for their place in the world, in the environment in which they have learnt to live for years.

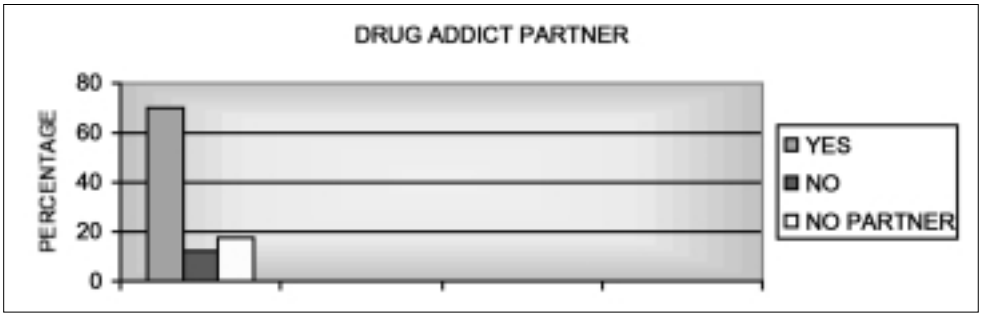
The relationship dimension

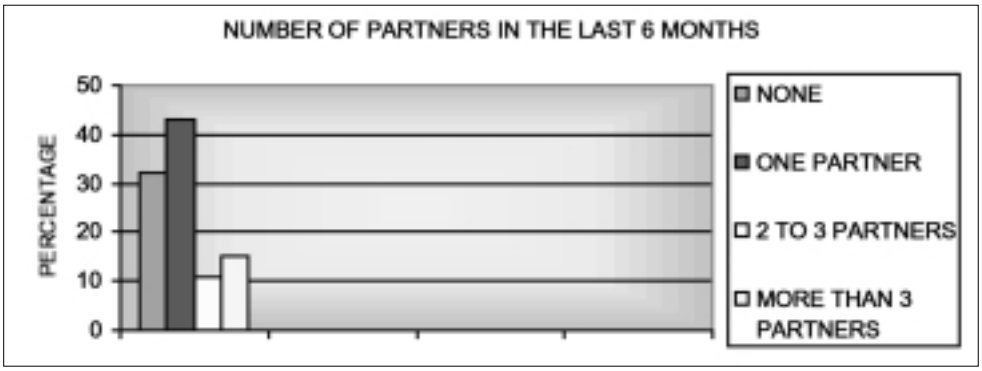
The **Influence of the Drug Addict Partner** on **Relapse** in the woman drug addict is yet another of the aspects of the man's determining influence in the whole process of addiction, including the **Initiation into Drug Use** or the impossibility of undergoing **Treatment**, according to numerous studies (Ellinwood et al 66, Allen 94, Llopis 97, Lye and Waldron 98, OEDT 01).

> "If my husband was using every day at home, how was I going to get off it...? It was impossible to start any treatment" (Mother, 34).

Previous treatments failed "because my partner takes drugs" (in treatment, 40 years old, Portuguese).

Practically all the women surveyed (70.3%) had had various different addicted **Partners** from the onset of their addiction, a fact which has had a varied influence on the woman's own addiction. The **Sexual Life** of the addicted woman demonstrates the significant differences which exist between the sexes. Practically all have sexual relationships (68%) and many authors indicate high levels of promiscuity (more than two partners in the previous six months) ranging from 31%, Llopis (97) to 77%, Borrego (94), with the significant feature that many of these partners are also addicts. In this study, 26% of the women surveyed have had more than one sexual partner in the





previous six months. Davies et al (96) reveal that women who inject drugs are more likely to have sexual partners who do the same.

> "When I met the man I'm with now, we were both hooked. He has had no influence on my habit, my first husband was the determining factor in my getting hooked" (Mother, 32).
>
> "We've always influenced each other's use... I've also played my part in his addiction" (Mother, 36).

The relationship with a partner who, as we have seen, is usually an addict, does not only bring with it the risk of the woman's initial contact with drug use, but also becomes more serious with the appearance of illnesses transmitted due to a lack of precautions, both through shared syringes and sexual relations. This is particularly brought on by the lack of honesty that generally goes with the addiction.

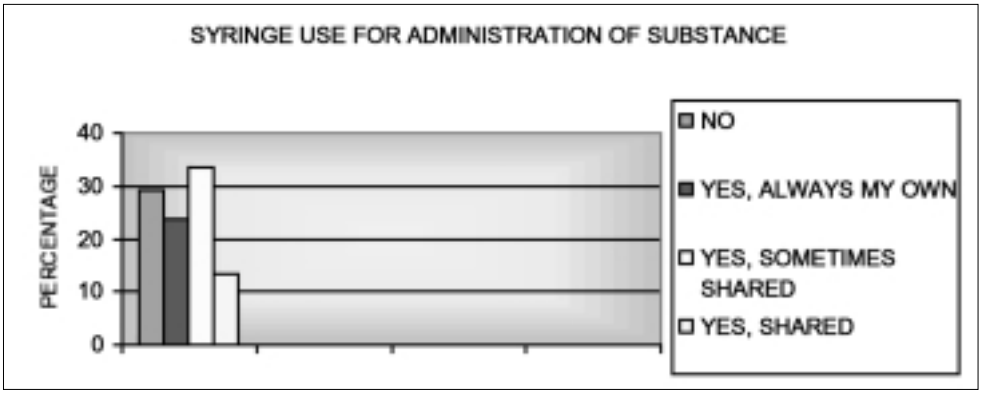
As mentioned above, numerous studies point to the addicted partner as a negative influence in the development of the trauma. This is manifest in the increase in the risk of drug use related secondary pathologies in the woman drug user, with a higher increase in the risk of infections than that experienced by men.

> "I got Aids through sexual contact before I started using drugs. I didn't know he was injecting and he never told me" (Sandra).
>
> "I've had three partners, all *junkies*. At first, they injected me because I didn't know how. I've been with my last partner for the last four years, and we're

coming off it, we just shoot up the odd time... we are more into heroin than coke" (María).

Of those surveyed, 45.29% have often **Shared Syringes**, perhaps because of the tendency to inject with their partner and share, or rather inject after he has done so, using the same needle and syringe previously used by him. Practically all authors coincide in that the greatest tendency amongst women is to share needles.

According to the 2001 European Observatory report, in spite of the tendency towards a decrease in the shared use of needles, this practice is still very high, with figures ranging from 17% in The Netherlands to 75% in England (OEDT 01). The same report highlights the frequent shared use of needles between stable partners.



In many cases, the perception of the relationship held by the woman and of how it has influenced her is frankly distorted.

> "I was with my partner for 8 years. At first everything was fine but then I had to leave him because he would come home every day and beat me up, and he wasn't doing heroin... I haven't had any more partners until now... he's on methadone and doesn't take anything. He's a gypsy, but he's a good man, and won't even hear injecting mentioned" (Laura, her previous partner was an excessive drinker and a regular cocaine user, while her present partner takes psychotropic drugs, as does she).

The relationship of the couple combined with the addiction of both partners does not seem to be a causal factor in **Conducts of Prostitution**, at least in a recognised form, amongst the women interviewed. However, 39% acknowledge having resorted to prostitution on occasion and are aware of plenty of instances of both men and women who have used prostitution to pay for their habit.

> "After one year, I was hooked. At first, you don't realise; I used to say I could stop when I wanted... I wouldn't get hooked... *(in a choking voice, holding back the tears*)... My sister injected me the first time and my other sister paid for it. They were older than me and I would go for the two of them so they wouldn't get felt up... I started working (as a prostitute) for her bloke, but when I saw that he

had put her to work on the main road, I said Fuck! Isn't one of us enough?" (María).

"If you are a woman they offer you drugs" (not in treatment, 30 years old, Italian).

"It's easier for a woman to find the money" (not in treatment, 38 years old, Italian).

"Drug pushers want sex in exchange for the drugs. Every one takes advantage of a woman" (in treatment, 35 years old, Italian).

In Spain, according to Borrego in 1994, 70% of addicted women and 12.3% of addicted men acknowledge that they regularly work as prostitutes. Statistics on prostitution are difficult to evaluate in comparison with other international studies since there is usually a clear bias in their truthfulness, which leads to excessively large oscillations ranging from 12% to 80 % (ORTE 98).

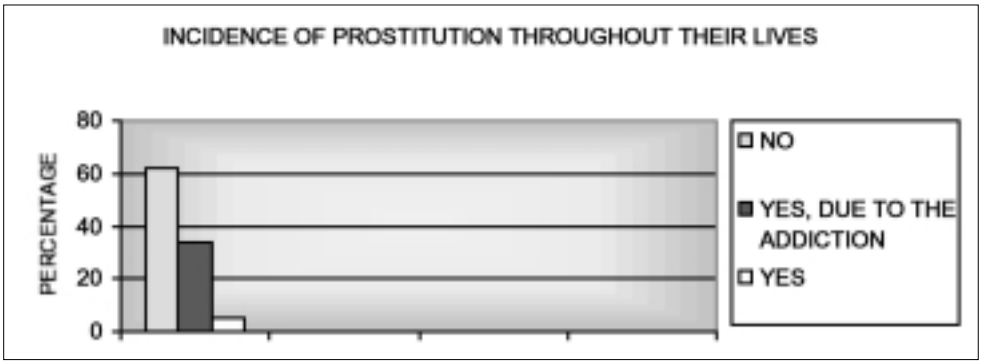
This data was confirmed during our previous study on "New Prospectives of Prevention and Intervention for Female Drug Addicts". The methodology of this study included a questionnaire and focus groups with the aim of studying if and how the problems of drug addiction are related to the aspects of gender identity.

When answering the questionnaire, many of the women who were interviewed stated that they had never been prostitutes and in the successive focus groups on the subject of prostitution, when the term was defined as the act of going on the streets and selling one's own body, those interviewed said they had never been prostitutes.

Only when the discussion turned to the fact that various forms of prostitution exist, and that this term indicates the act of trading any kind of sexual act for drugs, or protection, almost all the participants said that they had prostituted themselves at least once in their lives.

"It's true that a drug addicted woman has more resources to survive and also to obtain drugs".

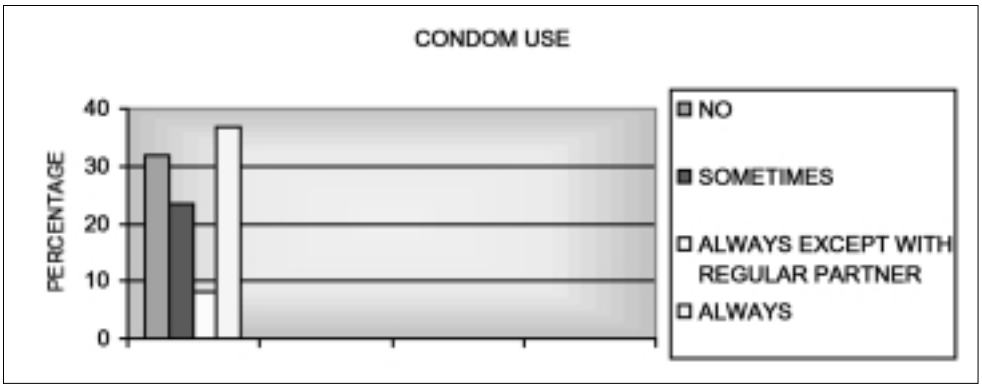
"Sometimes your self-respect comes into it, when you're a drug addict you realise that you can have certain things, but you lose your self-respect".



Bravo et al (94) found that women who share needles resort to prostitution more frequently, due to the higher level of addiction and fewer earning possibilities available along with the high cost of their drug use. At the same time, they are the group who are less likely to use **Condoms**, thereby entering into a spiral of risk factors which increases at an exponential rate. The same results were found by Davies et al (96).

In this study, 32% never use condoms in their sexual relations and 8% always use them except with their regular partner. We consider the latter information to be of particular importance, as it goes together with the tendency to share needles with the addicted partner, thereby increasing the risks to the woman. The latest OEDT (01) report also highlights the scarce use of condoms in sexual relations with a known partner, thereby leading to a continued high risk of contracting infection.

The UN AIDS Programme (UNAIDS/WHO 00) also indicates that80% of HIV infections are caused by unprotected sexual relations, and that women are a special risk group given their greater vulnerability as a result of biological, social and cultural factors.



The majority opinion associates addiction, women and prostitution, although the women themselves clarify certain points within this association.

> "People think that because you are a junkie woman, you start working the streets straight away" (Clara).

The women accept this association because it is a widespread social opinion and they confirm that it is based on an easily verifiable true situation, although it is not always the woman who must do this to support her drug use, and infallibly, that of her partner.

> "... Ninety percent end up doing that, but many are with a man who makes them go and work on the street" (Laura).

> "... it's easier for a woman to have a partner and get money" (María).

But get money for whom? This is an unanswerable question for the woman addict, since prostitution is often the way to finance the drug use for both herself and her partner.

THE DIMENSION OF MOTHERHOOD

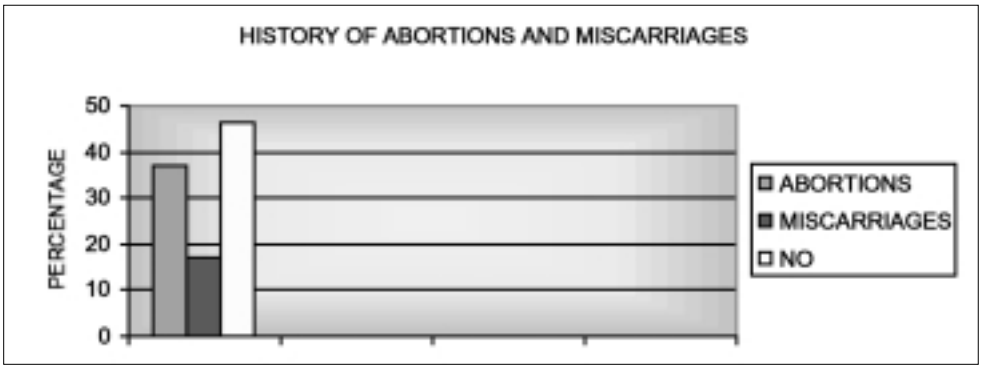
The analysis of the dimension of motherhood in the woman addict is an aspect requiring a particular approach in order to avoid falling into interpretations external to the addiction or which continue using the perspective disseminated by other studies on drug addiction which ignore gender distinction.

Most work on women addicts has focussed on aspects of motherhood in terms of the consequences of alcohol, cocaine or heroin use on the foetus, and not on the addict herself. By focussing only on the woman's purely reproductive aspects, whether or not she is an addict, her sexuality has been removed. Moreover, an excessive number of attributes have been assigned to motherhood in the addict, to the extent where motherhood or the "therapeutic pregnancy" has been considered as an event with positive repercussions in the development of the addiction, and even as a beneficial factor in giving up drug use.

> "I decided to stop because otherwise I would have lost my son" (in treatment, 30 years old, Italian).
>
> "Thinking of the children helps you stop taking drugs" (age not given, French).
>
> "When I first came to the community I found myself defenceless, this was my greatest difficulty and the little girl helped me discover the most feminine aspects of myself".

Our study shows that the dimension of motherhood requires a broad analysis focussed not only on the reproductive aspect, but also on the needs of the addicted mother and her shortcomings.

A high rate (54%) of **Abortions and Miscarriages** is found in our sample, and in several cases, various experienced by the same woman. Amongst the childless women in the study, only one has not experienced either an abortion or a miscarriage. Most of the 54% are abortions and related to the addiction, in particular to her social and health circumstances.



> "I was with my present partner and I got pregnant after going back to using".

"I was in bad physical and mental shape, as it was the first time I'd started using again after the treatment... that's what made me decide to have an abortion" (Mother, 30, abortion in the third month).

"My partner and I were both taking heroin and cocaine. We were out of work and didn't want to have a child with Aids" (No children, 34, abortion in the second month).

"I had one abortion, and then I got pregnant again and miscarried in the first month. Single, without a steady partner and using drugs..." (No children, 21).

In many cases, the decision to have an abortion is taken in the context of a feeling of immaturity expressed as not feeling ready to give birth or for motherhood.

"My partner is addicted, out of work and in treatment with Proyecto Hombre... I didn't think I was ready or mature enough to be a mother" (No children, 26, abortion in the second month).

"... I was in a relationship and we were both using but we didn't want to have children. Instead of using contraceptives, I got rid of it later" (No children, 28. Various miscarriages in the second month. One abortion).

"... I was out of work, taking drugs and I saw it wasn't the right moment to have a baby... I was hooked and I couldn't look after it" (No children. 4 abortions, the most recent in the fourth month).

The rate of miscarriages amongst drug dependent women is far higher than that of the general population. In Spain for instance, it stands at 17% according to 1993 Ministry for Health and Consumer Affairs data. The same pattern is seen with regard to abortions in heroin addicts when compared with general population rates.

In our previous study on *"New Perspectives of Prevention and Intervention for Female Drug Addicts"*, it emerged how difficult it is for these women to undertake the "work of pregnancy", starting with the conception, which often happened with casual partners or in precarious physical or psychological situtations (1998).

"The pregnancy was a bad experience for me, I always said I realised I was pregnant when I was in my fifth month, but that's not true. I knew I might be pregnant but I didn't do anything about it because I didn't want to face the facts".

"… giving birth was a very dramatic experience, even if I was convinced of the pregnancy and had already had a dramatic experience, it took 18 hours and there were many complications".

"… a woman also has to pay for her children, it's different for a man, for example, prison, being hit, for a mother it's different, there's both prison and also the children to pay for".

Due to amenorrhea, the lack of medical check ups and active drug addiction, many of those interviewed realised they were pregnant after six months, which, according to the legislation, is too late to have an abortion.

From the point of view of experiences in hospital, in some cases the treatment was considered to be dissatisfactory “a horrible experience that I will never forget”, while in other cases the absence of any particular attention from the medical staff was noted: “I think I was given routine treatment”.

> “When the doctor found out about my circumstances, he asked if I was going to have one child after another”.
>
> “The nurse or any other member of the medical staff only see you as the drug addict who is the cause of her child’s illness”.

The greatest concern during pregnancy was that all would go well and particularly, that the baby would not be born HIV positive or with any other problems. Some of the pregnant women were fearful that the baby would be taken away from them after the birth. It has been shown that in many cases, the main motive for looking for treatment is their responsibility for their children, as well as the fear of having them taken into care (Kline 96).

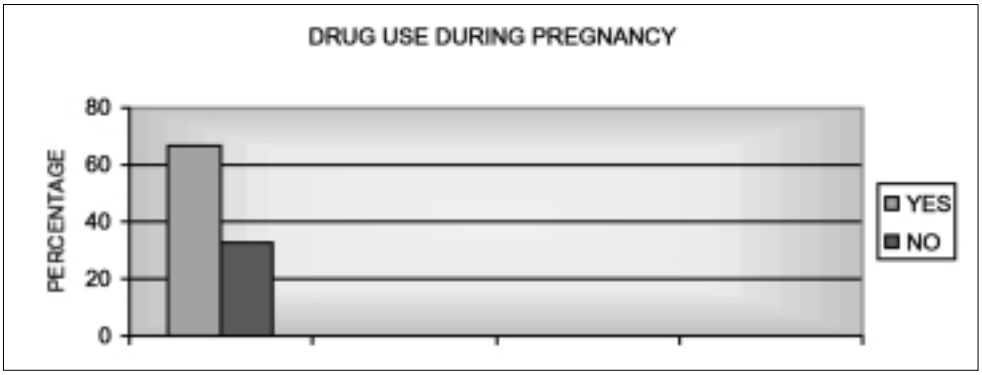
> “I took drugs right through the pregnancy, I was frightened that they would take the baby off me for being addicted... I was too frightened to go to the gynaecologist, and for the same reason, I didn’t go to any drug addiction service. I lived in a flat with my husband and another couple who were also addicts” (Mother, 36).
>
> “I started because they took my children away from me” (not in treatment, 34 years old, Algerian).
>
> “I stopped for my second child, all my money went on drugs” (age not given, French).

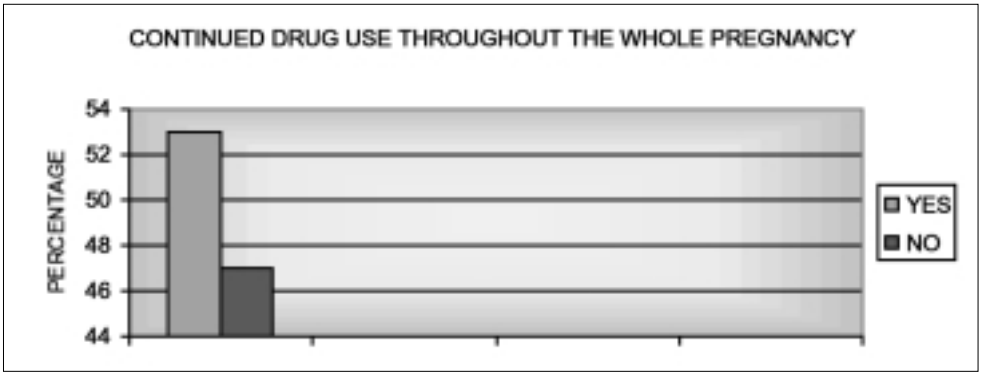
Generally, few of the women surveyed went for gynaecological check-ups during the whole pregnancy (36%), and for those women, the reason for doing so was to reduce or stop drug use.

There are very few cases of women receiving methadone treatment during pregnancy as, until recently, MMPs have been irregular and insufficient, with major differences between European countries which makes it difficult to compare access to these programmes. The coverage rate for substitution programmes in Europe ranges from between 7% and 33% in Portugal in 2000, 33% to 66% in Germany, 41% to 86% in Spain or 40% to 50% in France also during 2000 (EDO 01).

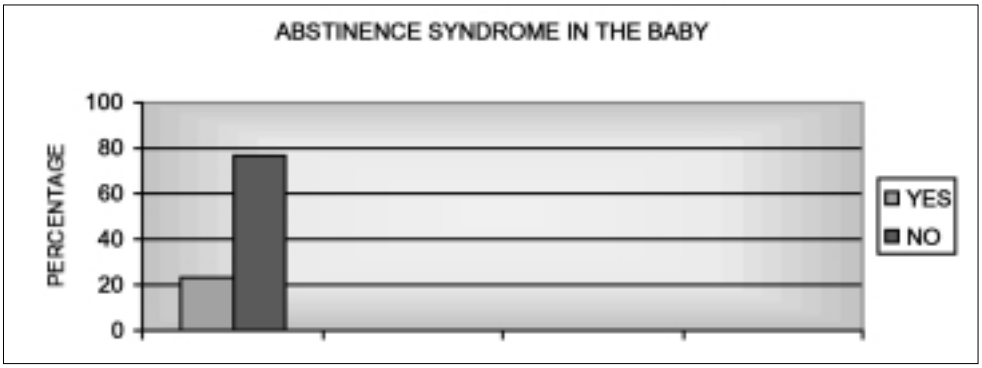
Of the addicts surveyed in this study, 67% were using drugs at the time of conception and 53% continued using throughout practically all the pregnancy.

> “During my last pregnancy, I used drugs sporadically, but only cocaine and alcohol. I was living with my partner; I went for my check-ups and went on working in the hotel until the end of the tourist season... I was concerned that my baby wouldn’t be born with any problems and that’s why I cut down on the drugs and went to the gynaecologist” (Mother, 30).





The Birth is often complicated by the presence of abstinence syndrome in the baby (23%), as a result of drug use, or of the opiate agonist maintenance programmes followed by the mother up to the moment of delivery. This generally leads to a stay in hospital of between two and forty days. Practically no incidents were discovered of discrimination against the newborn baby in the treatment received in the hospital. However, it is not uncommon for the mother to have experienced a discriminatory attitude on the part of the medical personnel, practically always gynaecologists and male health workers.



"I had awful treatment. They didn't put the baby on my stomach when he was born because I was a dirty addict. Then I had loads of haemorrhages and I was on the point of dying. They made me sign a paper saying I'd been seen by the gynaecologist, which wasn't true – in the delivery there had been an older nurse and a girl doing her practical... if I hadn't been a drug addict, that wouldn't have happened" (Mother, 33).

"The first time, they separated me from the rest of the women because I was HIV positive. They treated my baby well, though they kept him a few days in the incubator... the other births were different, they treated us well" (Mother, 34).

The relationship between the addicted mother and her child systematically appears as a matter of great concern which intrudes into other spheres of the mother's life, as the repercussions of the addiction are highly relevant to the offspring.

"When I was taking the stuff, my son stayed with my parents. My son is strong, he doesn't show any scars, I've always been with him... I'd only leave him for a few hours" (Ana, living with her parents and her son).

"My daughter doesn't show any scars either, but she must carry something inside... I've had to make a huge effort, but I managed to get her back on my own and work at it because my daughter has always been with my parents" (Clara, living with her daughter and her parents).

It is obvious that the addicted mother's vision of the **Mother-child Relationship** is somewhat distorted. They are aware that something is not working, but they resign themselves to accepting intervention from the grandparents while maintaining a merely secondary role for themselves of *"... being there and working at it..."* At the same time, they express their fear about the suffering which their addiction causes their children.

"... she hears everything (her daughter)... you can see that her stomach's all knotted. Not long ago I asked her if she was going to go and stay with her father this summer and she burst into tears straight away... she's seeing the school psychologist, and that's done her good. It must be hard for her because she's seen everything that's gone on" (Clara).

"... the ones who suffer everything are the children... it scares me" (Cristina).

"My son suffered because I was always nervous" (age not given, French).

"It's difficult to justify yourself to your son" (not in treatment, 41 years old, Italian).

Playing an active role as a mother and at the same time continuing with the addiction presents obvious incompatibilities in many cases. The feeling of incompetence and the recognition that they have not looked after their children as they should have is shared by all the European addicted women studied. The incompatibility of treatment programmes with the maintenance of the mother-child relationship has been verified through the focus groups where it was expressed as a generalised opinion.

It has already been pointed out that having children was one of the main motives for seeking treatment. In the same vein, it should also be pointed out that the condition of motherhood itself becomes one of the main hurdles to following treatment. On one hand, the fear that declaring her addiction will bring about the intervention of the social services, child-protection agencies or the courts, and on the other, the burden for the addicted woman of looking after small children goes beyond the therapeutic process offered by standard treatment programmes which provide very little support.

> "We've never received any help for the children when we've been in treatment... they've always stayed with our parents" (Cristina and Ana).

> "I didn't feed my son as I should have. He's always been kept clean, but he ate what there was" (Married, one son).

> "I have no trust in people who take your children away from you" (not in treatment, 30 years old, Italian).

> "I didn't make the decision to go to a centre because I was afraid I would lose my daughter" (age not given, French).

> "You should have "the possibility to take your own child with you in a therapeutic community until the end of the programme" (in treatment, age not given, Austrian).

This situation brought about by the addiction gives rise to a breaking up of the family relationship and deviations in family dynamics. Thus, mothers lose custody of their children, who in turn are taken charge of by their grandmothers and are brought up as though they were their own.

> "...my son and I have to keep to the rules that my parents set..." (Widow, one 15 year-old son).

Thus, the generation of the addicted mother disappears, with the consequences that this implies for subsequent stages of rehabilitation. The children lose respect and the maternal reference, and the grandparents once again exercise authority over the heroin-addicted mother, and treat their daughter and their grandchild as though they had the same status.

> "I couldn't look after my son because of my addiction, and they took him away from me... now my mother has custody and I see very little of him" (Separated, one son).

> "I have a 16 year-old daughter who lives in Barcelona with my parents. My mother took her when she was little and looked after her... it didn't cross our minds that I would take her... she knows I'm her mother. She's selfish. She works but she doesn't give my mother any money, and then she doesn't go home for two or three days at a time" (Cristina, addicted from the age of 14).

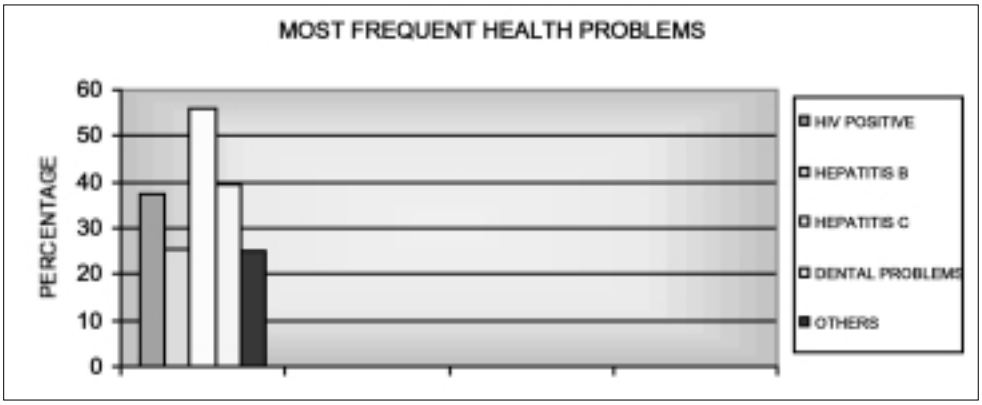
As for **Family Support**, calculated here with reference to the family member who takes responsibility for the treatment, Llopis (97) states that women go through treatment alone to a greater extent than do men, 51% and 37% respectively, and that family support for men

is also greater. The family member most likely to participate as the person responsible for treatment is the mother, but Llopis points out that this support is ambiguous, as it is often obstructed by the type of therapy programme the addict is following.

> "A member of my family gave me the energy to start all over again" (36 years old, Portuguese).
>
> "I hope my family wants to help me get away from drugs" (20 years old, Austrian).

The dimension of health

Women drug addicts suffer the consequences of their addiction/user habits particularly seriously. In general, we found a high number of HIV positive women (38%) and of Hepatitis B infections (26%) together with an alarming 56% of Hepatitis C infections. According to European Observatory figures (OEDT 01) the prevalence of the Hepatitis C virus infection is extremely high with rates ranging from 40% to 90%, although the limitations of the available data is indicated, both of infectious hepatitis and HIV.



In spite of the seriousness of these pathologies, the participants do not show a great awareness about illnesses, and tend to focus at most on HIV, while making light of other illnesses such as tuberculosis or sexually transmitted diseases (STD).

> "Health wise I'm as fit as a fiddle. After a relapse, your body recovers. Your head is what stays in bad shape" (Gracia, in treatment for Aids and ill with active hepatitis C).
>
> "I've had hepatitis C for the last 7 years. They said I was better, and I haven't been for a check up for years... but I don't notice anything" (Ana, ill with chronic Hepatitis C).

Lacoste and Gallo in 1991 identified one of the factors associated with HIV infection in women as being the high number of sexual partners addicted to intravenously injected drugs. They observed that only 44% of HIV positive women addicts used condoms in their sexual relations, and once they had been diagnosed as

sero-positive, still did not change this behaviour pattern. From this, it can be deduced that there is a constant increase in the number of cases of AIDS in women, especially in addicted women compared with men. This is particularly due to their relations with male intravenous drug users, through whom they are exposed to more hazardous drug use practices, but above all through sexual relations.

> "It's easier for a woman to get HIV compared to a man" (not in treatment, 37 years old, Italian).
>
> "A woman is more exposed to the dangers of the streets" (in treatment, 32 years old, Italian).
>
> "It's more difficult for a woman because of her body" (not in treatment, 32 years old, Italian).
>
> "A woman has more to lose if she is a drug addict, also because when you take drugs, you reach a state of consciousness that can make you do anything, you are no longe lucid and anything can happen to you".

According to the UN Aids programme (UNAIDS 00), 80% of HIV infections are caused by unprotected sexual relations. In contrast, intravenous drug use only accounts for 5% to 10% internationally, although it is predominant in many industrialised countries.

Of the HIV positive women in Western Europe who go on to develop AIDS, 40% became infected by heterosexual relations and a high proportion of them, through relations with addicted intravenous drug users (EURO HIV 2000). The same report states that the main factor in HIV transmission in women is the use of injected drugs (49%) followed by heterosexual relations (40%). In 1999, Portugal was the European country with the highest incidence of HIV.

According to the 1996 report of the Médicos del Mundo Mobile Unit in the Balearic Islands, of the prostitutes attended, 50% use drugs and of those, 80% prefer to inject, 92% find it difficult to use condoms in their sexual relations, 23% are HIV carriers and 43%, hepatitis carriers (Orte, 98).

The scant awareness of illness, together with the deficient information on their pathologies, is determinant on the health care habits of women drug addicts. The rate of treatment follow-up and medical check-ups is also alarmingly low.

> "My health is pretty bad. I had a really bad time on the farm. I've got Aids and hepatitis C but I don't take the treatment" (Cristina, ill with Aids, Hepatitis B and C and various STD).
>
> "I'm sero-positive but I haven't had an analysis done for years, I don't care. My partner and I do the same" (María, ill with Aids, Hepatitis C and in treatment for Tuberculosis*)*.

Certain psychological determinants appear to exist, elaborated as beliefs, which regulate behaviours related to physical pain and in particular, to medical treatment. In some cases, despite being aware of the need for treatment, these beliefs act to stop the

addict from taking the measures necessary to halt the development of the illness, and as detailed above, a conduct of continual reinfection through addicted or sero-positive partners is maintained.

Various authors have stated that socio-cultural barriers prevent many women from visiting centres for the diagnosis and treatment of sexually transmitted diseases (UNAIDS/WHO 00). Our opinion is that perhaps in the case of the women making up this study sample, this socio-cultural factor should not be underestimated as a determinant in their attitude towards their illnesses.

> "I keep my preventative medicines appointments for HIV, but I don't take anything because it makes me paranoid" (Sandra, ill with Aids, Hepatitis B and C).
>
> "They gave me some treatment but it made me vomit and gave me colic because I've also got liver stones so I stopped taking it... Then when I started taking it again, I started feeling nauseous and I think it's all psychological, but I'm not ready... I hadn't thought about it... but I do go for my check-ups, the viral charge is negative now, but I've stopped taking the treatment" (Clara, ill with Aids).

From these opinions, it is obvious that the psychological aspect together with distorted or insufficient health information lead to pharmacological treatments not being followed through, which evidently causes a worsening of the pathology. In particular, there is a direct relationship between syringe use, the sharing of injecting equipment, greater sexual activity, high rates of promiscuity, and above all, the scarce use of protective barrier methods in the sexual relations of women heroin addicts, as detailed by Llopis in 1997 and UNAIDS/WHO in 2000.

However, women do appear to be more aware of the fragility of **their Mental Health**. The psychological side of their well being concerns them, although few undergo psychological treatments. Participants in the groups drift in the ambiguity between what is necessary and what is urgent. In other words, they are between what they see as necessary and the anguish of taking on situations or conflicts which they do not believe themselves capable of resolving, a situation which eventually leads to any decision making being put off.

> "...I've got emotional and head problems that I've put to the back of my mind and when the right moment comes, then I'll deal with them" (Gracia, 30).
>
> "I've got a massive depression because of family problems (crying)... they never leave me alone and I don't have any relationship with them, they don't let me in or anything... my parents push me away" (María, 25).
>
> "I felt really empty, I was very sad and insecure" (in treatment, 28 years old, Portuguese).
>
> "I have had numerous existential crises" (in treatment, 37 years old, Portuguese).

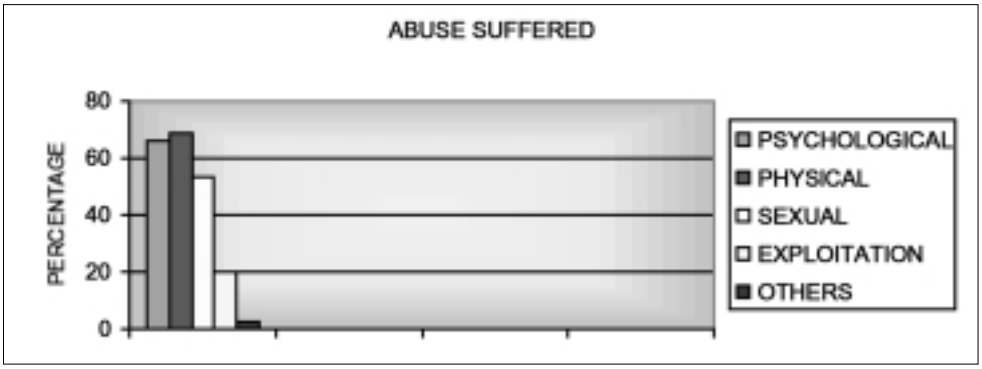
Psychological aspects are one of the key points in the discussion, with many issues revolving around the lack of affection, support or understanding from others, particularly in the relationship with their parents.

"I had no psychological or social support, not even from my family" (in treatment, 34 years old, Portuguese).

"I've had to make a great effort to get out... (sobbing) because my parents are dead and I've been all alone... to get out of one mess just to get into another... it's been a great strain all alone... without anybody. I'm depressed and I'm taking Prisdal. Before that I was on some other tablets" (Laura, 26).

"They prefer not to know, they don't want to know and that's easier for me too. Now isn't the right time for them to help me, I have to be myself. I want them to be there, but only there, for if I need any affection" (Gracia).

The incidence of **Abuse** is significant. In this sample, 69% state that they have suffered physical abuse and 66%, psychological abuse, in both cases during adolescence, and particularly once the addiction was established.



This abuse tends to be as a result of the addiction which evolves in the deteriorating atmosphere of the relationship with a partner, with the result that some of the women surveyed classify this aggression as being reciprocal within the relationship, and not abuse as such. A significant incidence of sexual abuse and aggression also exists within the context of the addiction, at the hand of either the partner or others with whom a slight relationship is maintained, often other drug addicts. Furthermore, 53% have suffered sexual abuse in childhood or adolescence.

"My partner was very violent with me, he was a psychopath... it has nothing to do with the fact that I was using drugs" (Mother, 34).

"I've been beaten since I was very young... we were both injecting, and the beatings came out of that" (No children, 26).

"They used to beat me up when I'd taken drugs and then they'd steal my money or my wrap (heroin dose), I've been sexually abused more than once" (No children, 32).

".. being captive to heroine, I also had to submit to many people sexually who robbed me of my self-respect".

"A woman can be raped by drug pushers" (not in treatment, 30 years old, Italian).

"Drug addiction degrades a woman, there's the problem of prostitution. In violent surroundings, a woman is weaker" (not in treatment, 38 years old, Italian).

With reference to **Antecedents of Physical and Sexual Abuse**, international literature on women addicts points out one detail we consider worth highlighting: statistics on addicted women in clinical groups report high rates of sexual abuse in childhood. In Spain, we have found only two studies which analyse this data. The presence of childhood sexual abuse antecedents is 1.5% in the study carried out by Llopis in 1997, which is a much lower result than those indicated in international literature (Blume 92, NIDA 94, Block 98) and in this study. According to other authors, experiences of childhood sexual abuse, in the main carried out within the girl's immediate family environment, can lead to a predisposition to alcoholism and/or drug addiction (Orte 98).

Physical or psychological abuse by immediate family members (22%) found prior to the drug addiction was also related to problems of alcoholism.

" My father has always beaten up my mother. I was the youngest daughter and I used to get home early to be there and try to stop him from hitting her. It was me who would go to the doctors with her. I was constantly on edge waiting for the next beating, and it made me suffer tremendously" (No children, 26).

"I remember lots of fights in our family, my father was extremely violent with all of us, he expected us to submit to him. We realised it was his problem and my mother wasn't able to do anything... she just cried".

"… I was always beaten, my parents were aggressive but I realised there was also some sort of affection".

"... when my father beat me, I took drugs out of spite".

Psychopathology in the family

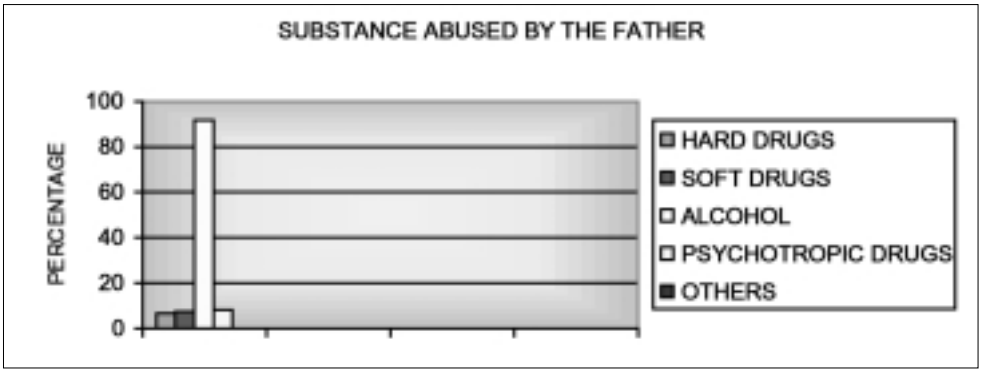
From our point of view, this dimension must be analysed with close reference to the previous dimension of the family relationship, particularly in view of the high rate of physical and sexual abuse suffered by women addicts within the nucleus of the family. Data from this study inclines us to think that the woman's addiction, or rather the woman herself, has grown and been "brought up" within a broken environment, within which maladjusted responses to conflict are the norm.

"I always had to be the man in the house because I had to take my father's place who was no longer there and I had to support my mother who has psychiatric problems. That's why it was very difficult for me to understand my more feminine aspects".

"I felt discriminated by my family. All of my sisters have problems but I felt really discriminated against by my father because I had disappointed him and he was ashamed of me. He threatened to throw me out of the family and the whole family made me choose a community far away from home, from my town".

For a more in depth analysis of the repercussions of psychopathological antecedents in the family on the configuration of the female drug addict personality, see the chapter in this book on the personality of the woman addict.

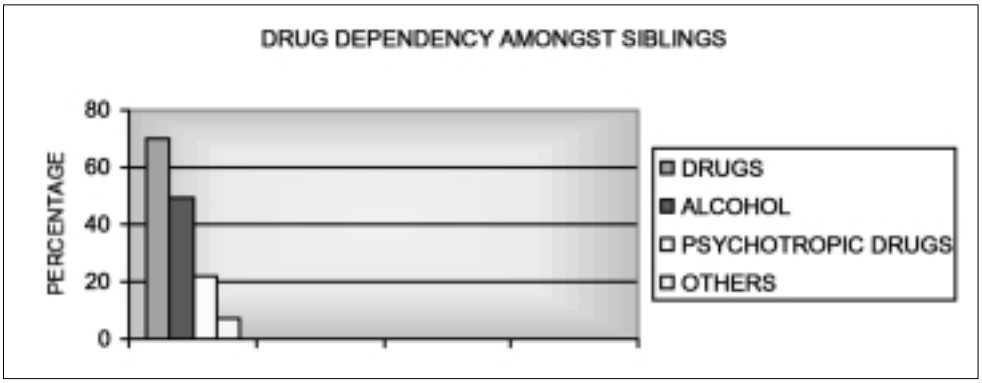
Above all, **Antecedents of Paternal Alcoholism** were found in the European sample, 92%. On the whole, no treatment had been received for this addiction.



> "Your relationship with your family does have an influence, a big influence... my father is an out of control alcoholic and he gets into states of depression. My brothers also drink, one of them lives with me and he does exactly the same as my father did" (Gracia).

With regard to the prevalence of psychopathological trauma in immediate family members, the literature reports that women heroin addicts live through a greater incidence of addiction traumas than their male counterparts. According to Llopis (97), 24% have an alcoholic father and 25%, siblings with opiate addictions.

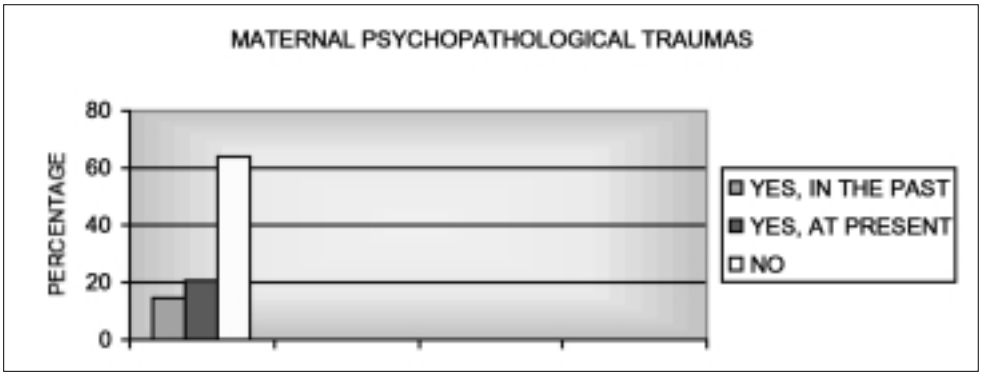
The family environment becomes more complicated when the high rate of Sibling Addiction, 47%, is taken into account. Of these, nearly 70% are opiate or cocaine addicts. The findings of this study clearly show that on the whole, women heroin addicts come from conflictive environments with severe breakdown in their upbringing and relationship patterns.



With regard to sibling psychopathological antecedents, all the authors highlight the high rate of addiction traumas, and report a greater repercussion in the case of women addicts (García López and Ezquiaga 91, Valverde et al 91, Ochoa et al 94, Spiral 95, etc.)

It should finally be pointed out that in Sánchez and Berjano's 1996 study, when contrasted with the control group, the most significant variables in the prediction of heroin addiction were paternal alcoholism antecedents and drug addiction in the addict's partner and siblings.

In the case of the **Mother**, **Psychopathological Trauma** antecedents are found which had continued up to the time of the study (21%), in all probability related to the high rates of alcoholism and drug addiction in the family.



DIFFERENCES IN ATTENTION IN THERAPY

Most patients in **Heroin Addiction Treatment** studies have had some previous contact with the drug addict care network. The women have undergone a high number of treatments of all types except in non-professional therapy communities. Out-patient treatment is the most commonly followed by both sexes. On the whole, women are less represented in addict treatment centres than men.

These gender differences are wide in all countries. According to the latest EDO report, the ratio of men to women under treatment is 86/14 in Italy, 85/15 in Spain and 84/16 in Portugal. The countries with the highest female representation are Ireland and Sweden with ratios of 70/30 and 72/28 respectively. The increase in the number of women on methadone maintenance programmes, particularly pregnant women, should also be pointed out (OEDT 01).

> "... in all the services only two of us were women... the nurses were unprepared and the psychologists were also busy in the private sector so they showed no interest at work. It was an odissey for the women".
>
> "…only two of us were women in the services and when we went for help, a consultent of the services themselves told me to stop, that we couldn't go on like that".

In truth, the differences in these ratios for women in treatment for drug addiction in specialised centres are the same as those appearing in primary health care services, where men more frequently receive non-specialised health advice on the use of drugs and alcohol (Roeloffs et al 01).

> "I don't know whether it's a question of sex, or of the individual" (Gracia).
>
> "I... think it's the same" (Ana).

The women are not aware of the existence of differences, even when the addiction is seen in a context of what are considered as deviant activities such as prostitution.

> "I don't think that there is a big difference between the treatment a man and woman can receive. If I was well treated on certain occasions it was because I met people who would have done the same with anyone".
>
> "I can't see any difference... in the Red Light district in Barcelona it was the same" (Cristina).

Differences are perceived unanimously in aspects concerning their involvement in treatment and to a certain extent, their dependence.

> "Women get sucked in easier and men have more willpower when they are in treatment... the possibilities for getting clean are the same, but the desire to do it isn't" (Sandra).
>
> "Women need special treatment" (not in treatment, 32 years old, Austrian).

Women are unanimously considered to be more psychologically dependent, perhaps because women seem to look for relief from physical pain in the effect of the drug. At the same time, they are considered to have greater resolution to leave the addiction behind, although with less external support (Allen 94), as we have already seen above.

> "Yes, we do get sucked in easier, but we're stronger when it comes to getting clean... me and my two sisters are all junkies and people say 'look, there go the.... girls, the drug addicts'. Families help men more than women" (María).

Although we have seen above that women seem to have less support when coming off drugs and going into treatment, the opinions of the group point to uniformity in the attention received, and do not mention therapeutic discrimination on the basis of gender.

> "I don't count the sex of the operators" (in treatment, 31 years old, Italian).
>
> "On the whole, I've been well attended" (Gracia).
>
> "I haven't noticed if they treated me better or worse for being a woman" (Cristina).

Despite the fact that the general opinion is that they received equal treatment, it is an opinion supported by an analysis by default of their experiences in therapy. The women in the group report that they are treated in the same way as are the men, and this is where the problem lies. They have been treated equally precisely because no account is taken of even the smallest specific differences and needs faced by women in treatment.

"They treat you the same as they do a man. Analysis, the same as everyone else, but never gynaecological check-ups..." (Ana).

"They don't look at the indivduality of a person" (not in treatment, 37 years old, Italian).

"The operators have to consider the people as individuals" (not in treatment, 34 years old, Italian).

In fact, it seems that yet again, treatment programmes are designed for men and it is the women who have to fit in with the programme, and not the programme that has to be adapted to the needs of the woman.

"Men are more comfortable at the Centre than with the psychologist, because they just think about getting over the cold turkey and keeping busy. The cold turkey doesn't worry me, it's the emptiness inside afterwards that I can't cope with... I don't know how, but I'll have to work at it, in a group or whatever... but having emotional contact is necessary" (Gracia).

Perhaps the most important difference is in the aspects concerning the addicted mother-child relationship while she is undergoing treatment, which often necessitate the mother having to decide between two apparently incompatible options.

"There are very few centres that take in mothers with their children, for me it's important" (not in treatment, 25 years old, Italian).

" I don't think it's a very good arrangement for us... not being able to be with your kids if you're in treatment is really grim" (Gracia).

On this point, we must bear in mind that for women addicts, the **Main Causes for Initiating Treatment** are the legal pressures deriving from the chances of losing or regaining custody of their children (Allen 94, Kline 96). This cause is followed in importance by personal desire and the fact that their addicted partner has decided to undergo treatment.

"I starter because they took away my children" (not in treatment, 34 years old, Algerian).

"I stopped because of my second child" (age not given, French).

The final point on treatment programmes and help for women heroin addicts is that they themselves are critical in their expression of the harsh reality that we as professionals cannot ignore as a result of the repercussions which have been felt over recent decades.

"I didn't get much help, but the professionals then didn't have the information that you've got now" (Gracia).

"I wasn't given the right information" (not in treatment, 22 years old, Austrian).

Conclusions

Factors such as employment instability and low skills, together with economic dependence on third parties are shown to be relevant to the prospects for change in addictive behaviour.

The relationship with a drug-addicted partner or partners is of vital importance, since it introduces a serious factor and very poor prognosis for the development of the addicted woman's pathology.

The important repercussion on related pathologies is directly linked to the widespread use of syringes, drug use habits and high-risk sexual practices.

The high rate of abuse both before and after the onset of addiction is significant. The presence of psychopathologies is markedly higher than in studies on male addicts, particularly of emotional traumas. Likewise, the presence of addiction related traumas in the addict's immediate family environment is a major factor.

Determining factors are motherhood and its consequences, high abortion and miscarriage rates, the circumstances in which these occur, and the role of the children.

These are aspects which mark the development of drug addiction in women and which give rise to notable differences reflected both on accessing treatment programmes and in the results of the treatment.

Given the important differences between male and female drug addicts, we consider it necessary to study in depth the possible influence of these differences on the prognosis and seriousness of the dependency and in the development of treatment for women addicts. The need for a different type of treatment for women's addiction must not be forgotten. Complementary programmes with external support should be developed to include issues such as the relationship with the partner, drug use risk factors, associated conduct and the attention and care of the addicts' children.

The final target is to be able to offer treatments which reduce the difficulties women face when approaching the change from dependent conduct to normalised conduct. IREFREA has continued in this vein through more specific gender and addiction studies into the obstacles to accessing treatment, or the influence and repercussions of motherhood on the various aspects of female addiction, the woman herself and her children. The results of these studies will be available in future IREFREA publications.

References

Allen K. (1994) *Development of an instrument to identify barriers to treatment for addicted women, from their perspective. The International Journal of The Addictions*, 29 (4), pp. 429-444.

Allen K. et al (1994) *Psychometric Assessment of the Barrriers to treatment instrument. The Internacional Journal of the Adictions,* 29 (5), pp. 545-563.

Ballesteros J. et al (1992) *Factores asociados a la no utilización de preservativos en adictos vía parenterl. Adicciones*, 4 (1), pp. 7-13.

Block J. Block J. H. y Keyes S. (1988) *Longitudinally foretelling drug usage in adolescence: eaerly childhood personality and enviromental precursors. Child Development,* n 59, pp. 336-355.

Blume S. B. (1994) *Women and addictive disorders. American Society of Addiction Medicine 1994*, pp. 1-16.

Bravo M. et al (1994) *Sharing Injecting equipment and sexual behaviour in ambulatory intravenous drug users: A national survey (Spain). The International Journal of the Addictions,* 29 (14), pp. 1893-1907.

Davies A. et al (1996) *Gender differences in HIV risk behaviour of injecting drug users in Edinburgh. AIDS Care Oct. 8 (5)*, pp. 517-527.

Dirección General Salud Pública (1995) *Interrupciones voluntarias del embarazo en la Comunidad Valenciana. Informes de salud n° 26*. Conselleria Sanitat i Consum. Generalitat Valenciana.

Ellinwood E. Sunter W. Vaillant G. (1966) *Narcotic addictions in males and females: a comparison. Int. J. Addict 1*, pp. 33-41.

Euro Hiv (2000) European Centre for the Epidemiologic Monitoring of AIDS. HIV/AIDS Surveillance in Europe. Mid year report 2000.

García Lopez A. Ezquiaga Terrazas E. (1991) *Estudio clínico- descriptivo por sexos de una muestra de 433 drogodependientes. Adicciones.* Vol 3, nº 4, pp. 349-357.

Ine (1996) *Encuesta de estructura salarial 1995.* Ultimas cifras 12/96. Instituto Nacional de Estadistica. Madrid.

Instituto de la Mujer (1996) *Mujer y drogas.* Salud XIII. Instituto de la mujer. Ministerio de Asuntos Sociales. Madrid.

Jang K. Livesley W. Vernon P. (1997) *Gender-specific etiological differences in alcohol and drug problems: a behavioural genetic analysis. Addiction 92 (10)*, pp. 1256-1276.

Kline A (1996) *Pathways into drug user treatment: the influence of gender and racial/ethnic identity. Subst. Use Misuse. Feb. 31 (3),* pp. 323-342.

Lacoste Marín J. Gallo Vallejo M. (1991) *La embarazada toxicómana ante el sida. Conocimientos y actitudes. Adicciones,* Vol. 3, n 2, pp. 141-151.

Lye D. Waldron I. (1998) *Relationships of substance use to attitudes toward gender roles, family and cohabitation. J. Subst. Abuse 10 (2),* pp. 185-189.

Llopis Llácer J. J. (1998) *Edad de inicio en el consumo de opiáceos y circunstancias concomitantes: Un estudio con mujeres heroinómanas, su personalidad y evolución.* Tesis Doctoral. Fac. medicina. Universidad de Valencia.

Llopis Llácer J. J. (1997) *Determinantes de la adicción a la heroína en la mujer: La codependencia. Libro de Ponencias de la XXV Jornadas Nacionales de Socidrogalcohol***,** pp. 363-398. Ed Dupont Pharma. Madrid 1998. ISBN 84-605-7459-8.

Navarro J (2000) *El Consumo de alcohol y otras drogas en el colectivo femenino.* EDIS. Instituto de la Mujer. Madrid 2000.

Nida (1994) *Women and drug abuse.* Department of health and human services. Public Health Service. Nacional Institute on Drug Abuse NIH publication, n. 94, pp. 3732.

Orte socias C. (1998) *Sexualidad, mujer y drogodependencia. Rev. Proyecto, nº 26. Junio 1998,* pp. 7-12.

Oedt (2001) *Informe anual sobre el problema de la drogodependencia en la Unión Europea 2001.* Observatorio Europeo sobre Drogas y las Toxicomanías. Lisboa 2001.

Palop M. (2000) *Mujer y drogas. Papeles del psicólogo*, n. 75, pp. 53-55. 2000.

Plan Nacional Sobre Drogas (1996) *Memoria 1995, Plan Nacional sobre Drogas. Delegación del Gobierno para el Plan Nacional sobre Drogas, Ministerio de Interior,* Madrid.

Registro Nacional de Casos de Sida (1996) *Vigilancia epidemiológica de SIDA en España. Informe trimestral Nº 5/1995. Centro Nacional de Epidemiología. Instituto Salud Carlos III. Madrid.*

Roeloffs C. et al (2001) *Problematic substance use, depressive symptoms, and gender in prymari care. Psychiatr. Serv. Sep. 52,* pp. 1251-1253.

Spiral (1995) *La mujer drogodependiente: caracteristicas, tratamiento y estudio de evaluación.* Fundación Instituto Spiral, Madrid.

Sanchez E. Berjano E. (1996) *Predicción de la conducta de adicción a heroína: un estudio experimental. Adicciones*,Vol. 8, n. 2, pp. 149-160.

P. Stocco (1991) *L'uso de la droga en la enfermedad de l'ideal Addiciones.* Revista de Socidrogalcohol, Vol. II, n. 4.

P. Stocco (1998) *La identidad femenina entre riesgo y protecciòn*. In: Adicciones, Vol. X, n. 3.

P. Stocco, A. Simonelli (1999) *La condicion de la maternidad, la funcion parental y el uso de droga*. In: Experiencias europeas de atenciòn a drogodependientes con hijos, coleciòn Haize Gain, n. 5, pp. 13-32.

Stocco P. Llopis J. J. De Fazio L. Calafat A. Mendes F. (2000) *Women drug abuse in Europe: gender identity.* Ed. IREFREA and European Commission. Venezia 2000.

Unaids/Who (2000) *Trends in the epidemic overtime.* UNAIDS/WHO Working group on global HIV/AIDS and STI surveillance 2000. *www. unaids.org.*

2. OPIATE ADDICTION: WHY IS THE FEMALE PERSPECTIVE NEGLECTED?

By Evelyne Mariani

This question proved to be the biggest difficulty in this study, as counsellors were unable to access sexual references from an epidemiological point of view and also with regards to specialist literature on the subject.

It would appear that drug addiction and its ups and downs completely dominate the attention and that sexual distinctions are very rarely made. With this one might say that addiction succeeds in its "operation", its "mission" as H. Fredda, one of the few psychoanalysts that has analysed the matter from a clinical point of view, quite rightly underlines. What he means to say is that the operation has succeeded, both for the subject who sees intoxication as his solution and for the community and drug addiction counsellors in general, as in comparison to the huge amount of literature produced on the subject, studies on addition amongst females are very infrequent.

This should encourage us to reflect on our stereotypical representations, on the way that they affect us, the community as a whole and the drug addict, be it a "he or a "she". Which operation are we talking about here? The operation by which male and female addicts alike introduce and express themselves using the world famous formula "My name's … and I'm a drug addict" at the start of the meeting, for this declaration of identity, this password to all pleas for help, also provides the perfect way of dodging the question of sexual distinction. This is followed by the silence that meets attempts at psychological and clinical investigations, with regards the family in particular, a silence that contains the message: no need to look any further. This is my birth (my first encounter with drugs) my life (my addiction) and my death (in the event that I be deprived of that drug and that is why I am here).

H. Fredda (1996) puts it like this: a drug addict is a person who has discovered the solution to the anatomical difference between the sexes: "this is the drug abuser's mission: finding a formula to his being that allows him to introduce himself to another, the intervening party for example […] as having found the solution to the gap that sex imposes in speech". Concerning the attitude of the intervening parties, the opposite of this denial, he writes "no conference has ever been held on feminine and masculine drug addiction… as from the instant in which one assumes substances, there is no longer a difference between man and woman. The evidence speaks for itself. So much so that the two are considered identical with regards to drugs. The same techniques are used for both genders […] and we therefore eliminate Mankind's true dilemma: the difference between men and women".

Once we have overcome this initial surprise of being faced with a void, a second surprise awaits us: literature on drug addiction amongst women does exist, but it only considers women as mothers and their access to maternity. There is a literal abundance of literature on the relationship between drug addiction and maternity: including the stereotypical social representations concerning addiction and motherhood and their incompatibility and we come to a real highpoint with scientific literature concerning the health risks involving women that are drug addicts, mothers and HIV positive.

In other words, when they become mothers, female addicts are treated with regards to their function of reproduction and, to an even greater degree, to their function of contamination only, thus denying them any claim to gender. These time-old phantoms rear their ugly heads under the pretext of health and social concerns: registration, control, screening and the desire to manipulate both mother and child. This is also where we encounter the first concerns about the conditions of her access to counselling, not so much as a woman, but rather as a mother.

This brings us to the following conclusion, before opening the real heart of our study, but it does not exclude relations with the family: the female addict only in her capacity of a mother only, and no longer in her capacity of a daughter and a woman.

This is the background concerning dominant social representations, at least those present in most European cultures, in other words the socio-cultural context that we automatically refer to constantly. Since the development of modern sciences, we know that the observer (the counsellor or researcher) is involved in the field that he observes and with which he is in constant interaction. Could it not be that these social representations, that also affect specialists, make up an integral part of the difficulties faced by female addicts? And does it influence, and this is the subject of this study, the way that families treat their daughters' addiction?

Reference data on female drug abusers

By taking into consideration the few discriminating factors found in literature, we are able to observe certain specific trends with regards to the consumption and lifestyle of female addicts:

- they often commence consumption younger than males;
- they often commence with psychotropic substances (or cannabis) and this consumption is likely to increase with age;
- they are often considered less socially «active» and therefore depend financially on their family or social support;
- their first counselling session often occurs later than with males, however once treatment starts, they tend to stay the course better than men.

For example, in France «l'Observatoire Français des Drogues» (1999) illustrates that for adolescents, girls (11%) are twice as likely to assume mind-altering medicines as boys (5.9%), and in contrast to trends amongst boys, this consumption increases with

age. However, this gap is much less noticeable in age groups between the sexes concerning cannabis consumption, where girls tend to experiment but do not repeat the experience and the contrary is true for alcohol, which boys consume in greater quantities and at all ages.

The study carried out by Irefrea France in December 1998 on "Les Rapports Sociaux de Sexe et les Toxicomanies en France" by F. VENNER and C. FOUREST (1998) pointed out that of a sample of 79 women interviewed, the strongest addiction was to heroin (41%), followed by pharmacopoeia (35.4%), "with a very strong multiple-addiction that is masked by statistics".

As previously noted by the participants of the European Seminar organised by the **Groupe Pompidou** (1993) "Women and drugs, minutes." the structure of female consumption differs from that of males, and whilst it is less likely to involve "addiction to one substance", multiple-consumption is more frequently observed. In order to evaluate the needs of these women in the six central and eastern European countries represented, it should be underlined that tranquillisers, antidepressants, sleeping pills and analgesics are the substances most commonly used by women. For example, in Slovenia, D. NOLIMAL noted that with regards to the high overall drug addiction figures in the country, "it is only with the consumption of prescribed drugs that we observe higher consumption levels amongst female users than males".

For example, in Germany I. VOGT underlines the low income and weak relationships with friends and family and the high number of female addicts with no fixed abode. In the Czech Republic, a study on addicted women and prostitutes in prison shows a high frequency of drunken behaviour and physical violence from parents, in particular concerning the various types of sexual abuse. And with Czech female addicts being treated in a Prague clinic there is a "strong feeling of rejection from the family home, which is much more noticeable than in males" (O. Pecinovska).

During the seminar, S. Sakoman provides a different picture of the situation in Croatia.

The majority of families was quite well-off, the parents weren't divorced but the father was often distant or absent and there was a higher than average number with a dead parent, often the father, alcoholic parents were more common to females than males.

The fundamental difference between the sexes seems to be the greater environmental difficulties for young males, caused by the absence of the father, which causes identity problems. Here female adolescents seem less vulnerable than males as the mother provides an adequate source of identification.

These differences bring us to make our first observation, which we will discuss later in the light of hypotheses concerning the attitude of the family of origin: **initial addiction in women is more frequently to psycho-active medicines and therefore to legal substances, than men, and as these substances are socially acceptable, use is not immediately labelled as "abuse"**.

These statistics, to which we can add those concerning girls with bulimia and anorexia that are considered addictions, show that abuse is often made of antidepressants «8% of females against 3.7% of males took sleeping pills or tranquillisers the week before the survey », and this already noticeable difference widens from 35-40 years of age and is even greater after 45 (L'observatoire Des Drogues, 1999).

We can therefore conclude that the consumption that starts in post-adolescent girls, followed by repetition and then their evolution towards a fully-blown addiction sometimes followed by the use of illicit substances often go unnoticed in a cultural context in which use of pharmacopoeia is accepted as part of everyday life due to their being legal and readily available at family chemists.

Similarly, the study conducted for Irefrea/France (Venner, Fourest, 1998) demonstrates that the first substance consumed by young girls is alcohol in 32% of cases, followed by cannabis (24.7%) and once again, we see that this substance is often familiar to the family context, and thus affects the way that families react to early alcohol abuse by their children. Coming to the heart of our study, the role of the family of origin, we also possess figures on the family's influence on the approach to counselling, however, if it was difficult to analyse the specific nature of female addiction, the task is even more challenging when we come to the approach to counselling and its motivation. Men and women are systematically grouped together concerning the origin of their first approach. We know, for example, that according to the OFD's figures for 1999, 45% claim to have acted under their own initiative, 18% were sent by a social or medical institution, 8.5% by the legal system and rather surprisingly we find a combined category for "Doctors and family", which represents 11% of approaches for addicts, without any comparative studies between the sexes.

In order to form a rough idea, the alternative is to use our own figures, those of the Alpes-Maritimes ITS, albeit a very limited sample but one that at least considers the differences between the sexes. In 1999, as in the 2000 Report, cases in which the patient was sent by parents peaked at 6-7% of those treated and if we introduce the sexual differential factor, we observe a considerable difference in family encouragement for the two sexes in sending their child to a specialised counselling centre: in cases sent by family 71% were male addicts, whereas a mere 29%, less that half of this figure, were female. (The remaining combined figures are as follows: personal initiative 63%, sent by the legal system 24%, sent by social or health institutions 13%).

«**The family helps males more than females**» stated a participant in the focus group of the study performed by Irefrea Spain in October 2000.

Our study will first tackle the general question of why families with an addicted son or daughter are so rarely involved in approaching counselling for the first time. This matter has already been abundantly dealt with in clinical, especially systemic, literature concerning the reports on this double link and taboos concerning the drug addict and his/her family and we will briefly summarise this.

Later, and this is the aspect more rarely dealt with, we will attempt to examine the relationship between female drug abusers and their family of origin in order to propose some hypotheses on reasons why young girls and female abusers involve their families even less in the contact with or encouragement to attend counselling. These hypotheses must be based on the European literature on the position of female addicts within the family of origin, the type of relationship that she had with her parents and siblings as a child and as an adolescent and the role and position that drugs seem to have taken within the family set-up.

Before opening this chapter, two points should be made:

- the lack of stimulus from the family not only demonstrates their attitude towards addiction, but also its degree of acceptance of the outside world and the idea of help from the exterior. The family may be aware of and suffer because of the addiction of a family member, but however, it tends to favour an intra-family approach due to a feeling of taboo and shame, but also of mistrust and closure towards help and solutions proposed by the community. The "exterior", for a range of historical family reasons, may be considered as negative or threatening to the family group and therefore encourages it to react to problems alone. To a certain degree, one might say that for some families facing the community represents a greater problem than the discovery of an addict in the family;
- the addict may also refuse or reject family encouragement to attend consultations, for the same reasons mentioned previously, thus sharing the ideas of the family model towards specialised help. In "Family Therapy" (1976), Ainsi Reilly mentioned that the drug addict's plea for help is usually addressed to one of his/her parents".

Family and addiction counsellors believe that addiction requires a point of resistance, or crisis with regards to the outside world (such as somatic problems or problems with Justice) that acts as a stimulus to commencing counselling, when the problem has often been part of family life for a number of years.

There are two additional, less important reasons for families not encouraging addicted sons or daughters to seek help from counselling centres: the ignorance as to their existence, which is somewhat improbable given the efforts made to inform the public over the last ten years (free call numbers etc.) and a breakdown of communication between the drug addict and the family, which is a rather rare occurrence, as the addict usually lives in the family or in a situation of pseudo-independence or financial dependence where the family continues to take care of the addict's most elementary requirements such as paying the rent or providing meals at the family home.

In some cases, partial occupational or residential independence is established, however the addict usually maintains a relationship with at least one family member (usually the mother). Despite the fact that for female addicts, sexual occupation may be

thought to provide a further reason for a deterioration in intra-family relationships, this is not always the case…

In a study published in «Family Process», NOONE and REDDING (1995) mentioned the very close links between addicts and their family of origin. A high percentage of their patients continued to live with their parents despite being aware of their son/daughter's heroin addiction, and that at whatever age, irrespective of whether they lived in the family home or not, addiction was directly stimulated by the problem of separation and individualisation. For several reasons, addiction represents a kind of «pseudo-individuation».

The addict's family of origin: a brief analysis of the situation

Drug addiction counsellors have long since studied the apparent relationship between the delay of the 1st counselling session and the level of alleged suffering of families attending their first visit. This usually takes place after many years in which the addiction has developed slowly but surely within the family.

The feelings expressed on such an ocasion are often violent, a rejection almost, which sometimes go as far as the expressing a wish to die, talk is made concerning the common suffering, and an urgent plea to eliminate the "cause of the problem", when the problem has been known for some years. It was also observed that once the problem had been «delegated» to the institution by the family, once the "emergency" solution (hospitalisation, treatment…) had been found, the subject and his/her family disappear without accepting the follow-up treatment offered, which represents the only way of obtaining a lasting relief or stabilisation of the problem, as it is the only means of exploring the intra-psychic and intra-relational causes of the addiction.

More often than not we observed that the family reappeared months or years later in exactly the same conditions and with the same request….

What was missing in the meantime was the possibility of giving those interlocutors the opportunity to conduct a reasonable investigation on the causes and the development of the problem within the family, due to their reluctance to discuss intra-family relations, communication, the past etc. "that's not why we're here, we're here to talk about him/her" as if the problem was completely isolated and without interaction with the surrounding environment. As counsellors, these facts brought us to use systemic theories, such as with psychosis, in order to try to explain this apparently senseless behaviour by addicts and this plan seemed to be particularly fruitful from a theoretical point of view, as each occasion presents a paradox: in this case, the declaration of independence that leads to complete dependence (to a substance, but through the substance to financial and emotional dependence and close relationships).

The psychotherapeutic follow-up obtained with the families of certain addicts, showed that even the heaviest heroin addiction can have a vital role in the family mechanism and is capable of organising a family in the very instant in which it threatens to disappear. The fact that, despite the suffering it causes, this homeostatic "function"

of the symptom contributes to its being subconsciously maintained, brought us to deduct that the origins of drug addiction could originate within the family's history and function.

Aetiological hypotheses concerning the role of the family in the appearance of addiction in one of its members have been formulated, on the basis of statistics and medical histories of cases followed-up in the family, together with the notion that it does not simply facilitate access to treatment, but can, in fact, represent an obstacle, similar to the subconscious reluctance encountered in psychoanalysis.

The key Hypothesis is that addiction does not merely demonstrate dominant intra-psychic conflict, it must also be considered as the result of severe relational disorders between the subject and his/her social and family surroundings (Le toxicomane et sa famille, 1983).

Nevertheless, the challenge lies in obtaining specific data on addicts' families as opposed to that concerning families with disorders, concerning distorted relationships between parents, grandparents and siblings. We are well aware of the dangers linked to the definition of a "typical profile" in clinical work and the risk of stereotyping that this approach can stimulate.

However, the following elements are those that are most frequently observed during studies and investigations, in the educational process, early shortcomings are often highlighted (Davidson, Defrance, Facy, 1980):

- a physically absent father, which can lead to either a lack of paternal authority or excessive authority in which the father is seen as an impotent attacker;
- one of the parents, usually the mother, has an excessively close relationship with the subject, often caused by her awareness of the addiction, which can lead to a certain attachment in cases where the other parent is violent, distant or absent.

Mothers are usually described as having a central, symbiotic position that can be compared to psychotic type relationships.

With regards to the family's interaction with and attitude to the addiction of one of its members, most authors mention:

- a huge parental refusal of the addiction;
- a difficulty in expressing its feelings adequately;
- the desire to escape is expressed by the consumption of psychotropic substances by or eating disorders of various family members;
- a predominance of early or unexpected deaths that are in any case not symbolised in the family (no mourning).

It would seem that the problem is not so much in the individual case, but rather the particularly high degree of rigidity and non-flexibility of these family models.

In France S. STERNCHUSS - Angel and P. ANGEL (1983) concentrated on such themes by opening the Centre Monceau in Paris, the first family therapy centre for drug

addiction. In an article written together with B. GEBEROWICZ for «Cahiers critiques de T.F. et de pratiques de réseaux» they review the figures available on sequences, links and interactions specific to heroin addicts. The following is a summary of this information:

- the existence of a widespread "family blindness" that we have already mentioned: the discovery of the addiction usually comes from outside the family, caused by a somatic or judicial problem. Often the addict leaves evident signs of his addiction (syringes, spoons, etc.) without these signs being seen. The authors give the following clinical interpretation "*the disclosure is a disturbance to the family set-up as new relationships have been created within…the youngster achieves the peak of his enjoyment by remaining dependent on his parents and at the same time giving the impression of a rebellion. And due to heroin's anxious and euphoric effects, the parents rediscover a kind, gentle and affectionate child*";
- the denial of the mortal gamble or the family's failure to recognise the risks that the patient runs, in keeping with clashes that touch the subject of death;
- according to the figures included in their article, family pathologies affect 50% of those interviewed. We will return to this subject concerning women later;
- typical family myths, such as the scapegoat function (STIERLIN), and the frequently perverse relationships within these families that cause an upheaval in the trans-generational process, are also mentioned, thus putting addiction on the same level as incest.

We will not dedicate any more time to these observations, they mainly concern the families of male addicts and our main objective is to study relationships with female addicts. In fact, in clinical analysis, ample space is given to the mother-son relationship.

We will restrict ourselves to our aim of using, from the rare texts available, the specific clarifications provided on relationships between the family of origin and the addiction of their daughter. What appears interesting to us in studies on both sexes and that concerns difficulties or obstacles to specialist consultation, is the idea that a kind of pseudo - equilibrium establishes itself around the addiction between the subject, the substance and the family, thanks to the secondary benefits of addiction and the relationships that it establishes between the parties. This morbid situation requires a crisis or the intrusion of an outsider in order to put it in question and cause an opening. We feel that this is extremely important to note in the case of female addicts: for example, do women react to the same exterior elements as men?

The family of origin of the female addict

Below follows a list of some of the epidemiological elements available on the medical history of female addicts, in particular with regards to childhood, those concerning the family nucleus (parents, grandparents and siblings) and those that can give us some indications on the position that the female addict occupied within the

family as a child. Our aim here is not to create a series of "risk factors" but maybe certain invariants in these stories that can give additional meaning to this behaviour and thus allow us to perfect the follow-up techniques used on these women.

Here we will quote mainly Spanish, French and British studies as sources.

- According to the IREFREA France study on women, addiction problems occur in the large majority of cases amongst siblings: 44% have pathologically addicted brothers or sisters, of which 57.69% to class A substances of which 50% also with alcohol, 81.48% have mental illnesses or judicial problems.
- RAUNDAL et VAGLUM (1994) worked on the same type of study in northern European countries and carried out a comparative study on 2 groups of women addicts in a therapy community in Oslo. The sample was as follows: 13 women in treatment for a period of 2 months were divided into two groups: the 7 women who successfully terminated treatment and the 6 who had a relapse at the end of the course of treatment.

The subject of this study concerns our aim of comparing the possibility of access to counselling facilities and a lasting improvement in patients' conditions with their childhood within the family of origin, and the resources or morbid characteristics that these surroundings provoked. The authors note:

With regards to parental relations, 5 of the 6 women who had a relapse had lived an adolescence with married parents, whereas in the group where treatment was successful, 3 had experienced a divorce between their parents and for two the father had died early leaving the mother widow. These elements may seems somewhat surprising, however it puts us on the clinical vision well-known to analysts that it is not so much the reality of the facts or in this case the ruptures, that are traumatic, but the way that they appear in the family conversation, with taboo "niches" that often make the consequences of a forcibly maintained marriage more harmful for a child than its termination.

The authors give further descriptions of the women in the two groups concerning their relationship with their parents:

- in the group of women who relapsed, the father is considered an "attacker" within the family, and treats his wife and daughter with the same rigid behaviour and with authority and aggression. This certainly involves tyrannical and over powering fathers;
- for women in the successful group, the father was seen mainly with indifference, and was physically or psychologically absent and it is interesting to use this as a starting point for comparing the paternal experience with their later choice of husband, knowing, as we do, the importance of the husband for women addicts in general: the authors note that the majority of the women in the "relapse" group have physically violent husbands "*they seem to repeat the destructive relationship that their parents had by choosing an aggressive partner just as their mother did*".

Repetition and addiction, addiction and repetition appear to be the recurrent themes that clarify the family history of women addicts and permit us to identify future intoxication. All the studies conducted so far in Europe and the United States show that compared to women on average, female addicts have been more frequently exposed to physical and sexual violence, that they were abused younger and for longer periods of time.

In America, for example, it has been shown that abused women remained addicted to legal and illegal drugs 4 times longer than those who had not been subject to this kind of trauma.

In the same way, studies conducted in Spain, especially that conducted by Dr. LLOPIS and REBOLLIDA, Irefrea Spain "Clinica de la Mujer Toxicomana: un analisis des actitudes" (2000) allow us to point out that: this study was conducted on a sample of 80 opiate-addicted women in treatment with Spanish counselling services.

The survey investigates possible aetiological aspects of relationships between addicted women and their family of origin, as a family psychopathology: most Spanish authors mention the higher frequency of addiction amongst siblings of addicted women (Ochoa 1994, Spiral 1995 etc). In 1996 Sandy and Derjano concluded that the most significant variables in forecasting the start of an addiction are past experiences of alcoholic fathers and drug addicted siblings compared with a control group.

This brings us to the following comment: **this situation involves families where addiction is already an everyday occurrence, in that it is part of the family's interaction or where substances regularly circulate freely (without necessarily leading to access to treatment, especially with alcoholic fathers)**.

In the systemic analysis of this phenomenon, one could say that in these families, addiction is the only way in which the family members are able to relate to one another, the only way they know of being a family; it is an integral part of their feeling of belonging, which become a "model" for the children.

In comparisons with the control group, in the above mentioned Spanish study, we find the following statistical elements:

- 30% of mothers of addicted women studied had a history of psychopathological problems linked to alcohol or drug abuse within the family;
- it deals with the important questions of violence and maltreatment «*international literature shows a very high incidence of maltreatment and sexual abuse during the childhood of addicted women*» (Llopis, Rebollida, 2000). The authors confirm that this abuse usually takes place within the girl's immediate family. According to Orti (1998), this is an important factor in alcohol or drug abuse.

  The study conducted by LLOPIS for Irefrea, shows that 84% of this abuse borne by addicted women is physical and 61% psychic and that it can take place during childhood or after adolescence. Sexual abuse during childhood concerned 37% of cases studied, or at least in those cases where it was admitted. This past abuse is often repeated with the choice of an abusive male partner.

This abuse of intra-family relationships that addicted women suffer early in life can be compared to the frequency of alcoholic fathers in Spain (41% in the group studied by Llopis, Rebollida, 2000), which is also often a non-treated alcoholism, which as we mentioned previously, is part of everyday life. Generally speaking, European literature shows that female heroin addicts have experienced relations with alcoholic fathers/opiate addicted brothers or sisters more frequently than males "*in an atmosphere of huge relational and emotional conflict and destruction*".

Later we will examine the consequences of these relationships and the question of «**the lack of self-esteem**» in these women, which seems to make them even more prone to the morbid and masochistic ups and downs of serious intoxication than men… we now know that on a clinical level, it is in the family, and the mother's attention in particular, that the bases for this self-esteem as a kind of narcissism can be acquired.

The analysis of the relationship between an addicted subject and the family always involves more than two generations…in a trans-generational upheaval that may also involve the confusion of roles between children, parents and grandparents that one finds in families with psychotic transactions. The Spanish study, due to the similarity of the social context in which it was conducted, provides us with some valuable information on this subject, especially on the position occupied by grandparents. In fact it reveals the hold that grandfathers have on their wives, an influence that the wife accepts with resignation, which is probably due to a strong sense of maternal incompetence reactivated when they have a baby.

Once more one might think that the secondary and certainly unconscious benefits that the family may draw from this situation are more powerful than the suffering caused by the intoxication of their daughter: this is the all-powerful, almost demiurgical possibility of skipping a generation in which the grandparents gain another child by taking the place of the parents, when the mother remains "a girl" (or even worse, the mother lives as an older sister of her child) and the transmission will only take place with the loss, the loss or acceptance of the succession of lifecycles and the influence of generations on the generation beneath.

Is one possible consequence of drug addiction not that a child may die before her parents, or in extreme cases, before her grandparents?

The Spanish authors also mention a "**perversion of family mechanisms**" that surrounds the young female addict: «a generation, that of the addicted woman-mother, therefore disappears, together with the possibilities of rehabilitation. The children lose their respect and a maternal figure and the grandparents return to exerting a dominant influence over the addicted mother, which puts her on a level with her child…» This rather bleak clinical situation may well evolve, however, it should be pointed out that this "perversion" can only work or develop if the addiction persists, as any attempt at counselling or withdrawal will pose an unconscious threat to the drug's constant function, the young woman can then work on gaining back her status as a mother and thus her relationship with her child. This causes acute suffering within the family and often we observe such circumstances in the young women who request methadone treatment in an

attempt to win back their child, and in such cases the stake becomes the child, where the grandparents foretell death and the daughter in treatment is forced into a relapse.

As Llopis (1997) points out, this is doubtlessly a fundamental reason why in Spain, as in other countries where the various generations are entangled, men are more often encouraged to undertake treatment by their family of origin (51% of cases) as the function of the family system is less threatened by external aid and the perspective of change. Women often have to face this approach alone. In the family of origin it is most often the mother who is most involved in her daughter's treatment, but, as the study underlines, in a rather "ambiguous" way, because she assumes the role of person responsible for the treatment supplied to her daughter, of whom she remains the highest relational level, which consists in continuing to dominate and baby her.

At the end of the study, the authors come to the following general remarks:

- the relationship of economic dependence and submission that these women have with their family is more socially acceptable than for men: the lack of financial independence for a woman is more socially acceptable as being "natural" and therefore does not particularly worry the family;
- this dependence on the family is prolonged into the relationship with the partner with whom the same dimension of submission in the previous relationship is repeated. This passive role in the woman's family and social life contributes to her addiction being overlooked by those surrounding her. Even with regards to the substance, the male is usually considered as the "initiator of consumption" and therefore has an active role.

The Spanish authors quite rightly highlight the notion of bi-addiction of the addicted woman, which more than for males bring her to a failure to recognise herself and her problems, her individuality and her personal needs.

A few provisional conclusions

From what we have been able to study on a European-scale, the relationship between addicted women and their family of origin causes a series of developments. On a clinical level we can safely say that in the way in which institutions treat these women, but also from a psycho-sociological level, knowing what we do about drug abuse, consumption is closely linked to the community, its stereotypes, make up and roles.

It is on this dual level that we will hazard a few generalisations on the basis of these studies in order to provide some guidelines applicable by all:

A) On a clinical level

Various factors show that it is the family, in its structure and unconscious disorders, that is doubtlessly involved in the origin and probably in the maintenance of addiction: all this suggests that this type of behaviour often originates with the family and that it

is there transferred onto a social level through relations with the community linked to adolescence which contributes to making them known and then leads to a series of somatic, psychological and judicial problems, which we are familiar with.

Having said this we can suggest the reasons why, despite the suffering entailed, the family seems very uninvolved and often does not encourage young women to approach counselling centres. The ambivalence of the family's attitude seems to occur in most cases, and the denial and resorting to detrimental behaviour is frequent. This is even more so than for male addicts and it is this difference that prevents young girls accessing medical care or psychotherapy at an early stage, and it is on this that we should concentrate.

It would seem that these families, due to their history and fragile identity that permit little contact with the external world, prefer to favour the prolonging of dependence that is part of their family make up, often from several generations beforehand (emotional, financial and sentimental dependence), and they prefer to pay the high price for the psychic suffering and morbid situation, rather than permit the recognition of this dependency and ask for help. There is often a real "family history of dependency" in such families, of which the young woman is a carrier. They are often well aware that this request can result in a re-examination of the problem presented, and the illusion of the happy family that these families nurture. The narcissistic blow to the family's image of itself caused by seeking outside help is even greater for women, due to the detrimental social attention from common social stereotypes of female roles. Here the feelings of shame and taboo seem to prevail and the young female addict prefers to participate in this closure rather than be seen as a bad daughter or a bad mother.

B) On a psychological and sociological level

With this regards, the points raised by M.L. Ernst of the Federal Office of Public Health in Switzerland in his text «Promotion des offres de prise en Charge bas seuil pour les femmes toxico-dépendantes» appear pertinent: «*the problems caused by addiction only help to underline the inequality that exists in society* » *which shows a stronger social discrimination, the presence of violence* in its history and the feeling of being controlled once more that is sustained by institutions. From our position as counsellors, this cannot take the form of a projection of problems on social attitude alone, but on the problem of a subject, in the first place, linked to a family problem and judged by public opinion. With regards to this reciprocal interaction between these different factors, we will quote the analysis conducted by N.CARDINAL (1988) in his study on addiction: «*Living according to traditional female stereotypes may seem problematic or may become a source of internal conflict (which we underline) for modern women. Social expectations may cause them to feel inadequate and their personal adaptation strategies may appear unsuitable….*

The anxiety that originates from internal conflicts or conflicts from the interaction of the woman with her family is a determining factor in the use of non-medical drugs»

and later the author underlines the lack of self esteem that these women possess as the most powerful psychological factor in intoxication «they have a marked tendency to underestimate themselves and deride their role…They resort to alcohol and medicines in order to reduce the anxiety or to modify the attitudes that they consider non conform or undesirable. This behaviour is a source of anxiety in itself as it does not conform to the woman's social ideal», and here we come back to our topic, or rather the importance of the family of origin in the way in which the subject develops and in her relations with her surroundings : «*self confidence is something that we learn from our families…»* and we have observed this: alcoholism, sexual abuse from fathers, pathologies amongst sibling…silence must reign in the family and it is often followed by a choice of partner that repeats this trend. We are often surprised during family therapy of the way in which the partner, even when he is also an addict and potentially dangerous, is quickly and easily not only accepted but also included by the addicted woman's family.

Female drug addicts reveal the complexity of relational gambles in the family, which often originate several generations beforehand. Motherhood constitutes a crucial emotional gamble that mobilises trans-generational disorders on which the family system tends to rest. The addicted woman's renunciation of these gambles seems to be more important than with males, it muddles generations and roles, thus making the search for help from the outside world even more complex and therefore making the child an essential sentimental element that protects the adults around him.

It would appear that the passive female identification that is often connected with the mother figure and exposure to abuse, as well as the social stereotypes in force concerning the passive role of women, causes her to apply herself to the overall needs of the family system to the expense of her individual needs, such behaviour is much less frequent with males.

All the elements that we have attempted to examine on a clinical and socio-clinical level concerning the specific nature problems amongst female addicts can be identified in the central concept of "**acceptance**", **the family acceptance as well as social acceptance of the first intoxication behaviour, addiction and its consequences** and that seems to us to be the first obstacle in approaching treatment. Young women appear to be the main victim of this acceptance, but participate due to the archaic order observed in the family of origin during childhood and that later involves dominant social and family roles.

All this contributes to the silence that we mention above and therefore the seeking help.

Perspectives

Current or future motherhood seems to provide addicted women with the biggest obstacles in approaching care and at the same time the possibility for her to find the specific resources for facing the intra-family problem and attempting to leave it behind.

Very often the young woman approaches counselling in order to exert her role as mother, having been stripped of her role as a daughter and woman.

In addition to this, for young women using drugs, usually still living with the family, there are acceptance factors that should be recognised and fought.

In both cases, we feel that the most fertile perspective of shelter and treatment lies in the earliest possible mobilisation of the family of origin, that should not be seen as an accusation, but rather a therapeutic lever, by working on its history to reveal the upheaval of the stakes that the drug addicted woman is a carrier of and in order to help to work towards a rejection, the rejection of generations of dependence, which permit prevention for the children and free the personal resources of young women towards treatment and a sexual future.

References

Cardinal N. (1988) *La femme et la toxicomanie.* In: «Precis des toxicomanies» J. Bergeret et Collab. Masson, France.

Dadidson Defrance Facy F. (1980) *Le toxicomane et ses environnements.* Recherche INSERM, France.

European Seminar organised by the Groupe Pompidou (Prague November 1993) *Les femmes et les drogues*. Actes, 2e seminaire Europeen Editions du Conseil de l'Europe.

Fredda H. (1996) *2e Cenférence Europeenne ERIT.* Paris 1996 cit. In: «Revue Interventions», Juillet, 55.

Le toxicomane et sa famille (1983) Ouvrage collectif sous la direction de Cahiers critiques de thérapie familiale et de pratiques de réseaux. Ed. Universitaires, 6.

Llopis J. Rebollida M. (2000) *Clinica de la Mujer Toxicomana: un analisis des actitudes.* Irefrea Espagne- OCT 2000.

L'observatoire Français Des Drogues. Edition 1999.

Noone Redding (1995) *Family process.* Cit. In "Le toxicomane et sa famille".

Venner F. C. Fourest (1998) *Les rapports sociaux de sexe et les toxicomanies en France.* IREFREA, France – Rapport – decembre 1998.

Raundal Vaglum (1994) *Treatment of female addicts.* The International Journal of the addictions.

Sternchuss - Angel S. Angel P. Geberowicz B. (1983) *Critiques de Thérapie Familiale et Pratiques de Réseaux*.

3. GENDER ORIENTED TREATMENT IN RESIDENTIAL LONG - TERM THERAPY

By Legl Thomas

The aim of this article is twofold: alongside providing a short overview of the state-of-affairs in European gender-oriented addiction treatment and more concretely putting these findings into the perspective of residential long-term therapy in a therapeutic community we are going to present the structure of an Austrian therapy institution with particular regard to the way in which gender-oriented approaches are being implemented in both gender-separating and gender-integrating settings. Moreover, and this forms the very core of this article, a focus group studies were carried out among both male and female patients at the TC "Marienhof", trying to establish their responses and attitudes to gender-related issues in drug therapy.

As a backdrop against which these results can then be better evaluated, it might be worthwhile to sum up as concisely as possible the past and present discourse on this issue within the scientific community and place it into relation to the particular circumstances for therapy in a therapeutic community.

A critical review of the relevant literature yields several significant trends which are presented here and consequently discussed in more detail:

- gender-specific approaches are often synonymous with female-specific approaches. Methodical proximity to feminist theory (Ruben 1995);
- historically, male drug-users were regarded as the norm, according to whose needs therapy concepts were initially developed. Women were increasingly perceived to be somewhat deviant from this norm and in need of specialised programmes - analogous to the development of other target-group specific therapeutical offers (families, adolescents, double diagnosis etc.). (Copeland, 1997, 184);
- move from mixed institutions to female-only institutions (Hedrich & Rua dos Ferreiros, 2000, 17);
- the specific demands of female patients are primarily evaluated along biological - motherhood, drug consumption and pregnancy (Hepburn, M. 1996; Fischer e*t.al.* 1998 - medical -HIV, hepatitis, gynaecological care (Lindebø, 1997)-, social - female drug-users and prostitution, homelessness, labour-market intervention (European Commission 1998)- and empirical parameters - consumption patterns (Gossop *et.al.* 1994) - whereas the psychological background for gender-specific, addictive behaviour tends to be neglected;

- gender - specific issues in addiction treatment have not yet found access to national drug policy on an equal scale throughout Europe. While in some countries, specific services are mainly provided by local or regional public health administrations (e.g. Portugal, Slovenia, Denmark, Sweden), in others, practically all are provided by NGOs (Germany) (Hedrich & Rua dos Ferreiros, 2000, 13). As a category within institutionalised statements of policy, female drug-users again mostly figure under the heading of "family" or related fields;
- flag-bearers of gender-specific approaches in addiction treatment are mainly community-based agencies outside the context of residential long-term treatment. This presents a challenge to "traditional" TCs in particular. – Danger of remaining stuck in a posture of "new orthodoxy". An evaluation of the state of existing offers can create a higher awareness for patient's needs and the possibility to respond accordingly (Hodgins, 1997, 811).

From a historical point of view it has to be stated that female-specific therapy offers where first initiated by "dissident" therapists from mixed-gender institutions in the late 1970s and early 1980s. Significantly, this movement originated in the Scandinavian countries (Björling 1997, 100) where gender-related issues have nowadays also gained a strong foothold in national drug policy.

This pattern of amending structural deficits in existing institutions is currently still valid when it comes to implementing gender-related aspects in therapy. In a kind of dialectic process the factors that hinder women's progress in therapy or access to therapy when compared to their male peers are isolated and addressed. Treatment barriers as these factors are known (Ettore, 1992, 67ff) have become an important concept in the literature. The most common barriers that were thus identified include a higher degree of social stigmatisation to which women are exposed as soon as they become identifiable as users of illicit drugs, lack of support from a partner (which is intrinsically connected to the problem of co-dependency) and lack of childcare facilities for addicted mothers. As a consequence, gender-related approaches tend to focus far more strongly on women than on men ("the other gender"). Whether this is a good thing or not remains debatable. While needs of women were previous certainly underrepresented in both research and practice and can thus be brought into the limelight, gender-oriented approaches might also have something to offer to men. Moreover, an examination of cross-gender relations or relationship patterns demands *per se* the involvement of both male and female gender issues.

This last issue addresses a widespread representation of female drug users in the literature. The needs of female drug users are sometimes too readily associated with those of drug-using mothers.

While the importance of therapy facilities for mothers with children cannot be stressed strongly enough, it is however worth discussing whether this strong emphasis on women as mothers might not distract from other gender-related aspects in therapy and constitute a barrier in itself, inasmuch as it could conceivably convey the impression that female drug users who happen not to be mothers are not equally well

catered for. Moreover, there appears to be the trap of confining women to yet another traditional social role, when one of the foremost objectives in gender-oriented therapy should be the questioning of accepted gender-role behaviour.

Similarly, many existing community-based, low-threshold service providers tend to reach out to very specific populations of female drug users, like prostitutes or pregnant drug-users (Hedrich & Rua dos Ferreiros, 2000, 12). For practical reasons, such an approach is definitely desirable on a grass-roots level, as an immediate means of intervention in communities particularly afflicted by certain social problems.

In an effort to achieve long-term success in addiction treatment however, a more far-reaching approach to the needs of female drug users seems to be called upon, i.e. above all an approach that is not exclusively restricted to social symptoms of addictive behaviour but rather attempts to tackle the very root of the problem.

Therapeutic communities seem to be well prepared to meet these demands: Theoretically rooted in humanistic psychology, the whole human being is the centre of attention. Moreover, many TCs have gathered valuable experience in deploying special programmes (adolescents, double diagnosis) in recent years, thereby proving that integrative treatment with individual emphases can produce most beneficiary synergetic effects. Social therapy can be combined with psychotherapy to address patients' problems on several different levels.

Another asset of TCs its their long-term focus and a distinct emphasis on continuity. Contrary to many local service-providers who can maintain but a casual and irregular contact with their clients and whose interventions are thus bound to remain within the limits of harm reduction and social work, clients in a TC setting are already removed from the social environment in which the symptoms of addiction (health problems, crime, prostitution, unwanted pregnancy, child negligence etc.) initially surfaced. A move from outpatient treatment to residential treatment hence provides the opportunity to confront gender-specific issues from an intrinsic - i.e. patient-centred – rather than from an extrinsic – i.e. concentrating on the addict's deficiencies in interacting with society at large – perspective.

An important initial step towards this goal is the very entry of the patient into a new residential environment in a TC setting, which equally marks the onset of the central process of disentangling the virtual web of pathological dependencies which users of illicit drugs typically find themselves caught in. Dependency should indeed the key concept when it comes to introducing gender-oriented aspects to residential long-term therapy: Not only are drug users evidently dependent on drugs, but – more crucially and essentially determined by gender-role behaviour – display an equally harmful pattern of dependencies on an emotional and social level. Hence, therapeutic communities should be able to make sure that no continuation of acquired systems of dependencies as they are common in the drug scene can take place in a therapy setting.

An influential characteristic of the drug scene in this context is the fact that relational and particularly sexual dependencies are often hidden behind a professed

libertine attitude towards partnership prevalent in the "scene". In fact, the idea of an allegedly free-for-all lifestyle based on voluntary participation barely manages to mask the sordid reality of exploitation and abuse. Utmost care has therefore to be taken not to let these attitudes and the continued self-delusion that goes with it and represents a central characteristic of dependent behaviour, enter into the therapeutic community, especially in a mixed-gender environment. The application of findings on gender-specific differences in relationship-patterns and the individual analysis of gender-role behaviour could prove to be an appropriate means towards improving conditions for success in therapy.

By its very nature, the concept of dependency is a bi- or indeed multi-polar one; particularly so when dealing with gender-role determined dependencies in relationships, in the sense that it most commonly involves persons of different gender. Bearing this in mind helps avoiding the reduction of gender-related issues to purely women-specific issues and is yet again well in tune with holistic principles underlying the structure of therapeutic communities.

Most existing residential long-term, TC-type therapy institutions seem to be well prepared for an application of gender-oriented approaches by virtue of their experience in the addiction field and the fact that they have a very elaborate therapeutical infrastructure at their disposal which can be readily adapted to particular needs of patients. Case-sensitive decisions can be taken on a highly individualised level as to which therapy setting is best suited to a given patient's need: single-gender or mixed-gender environment.

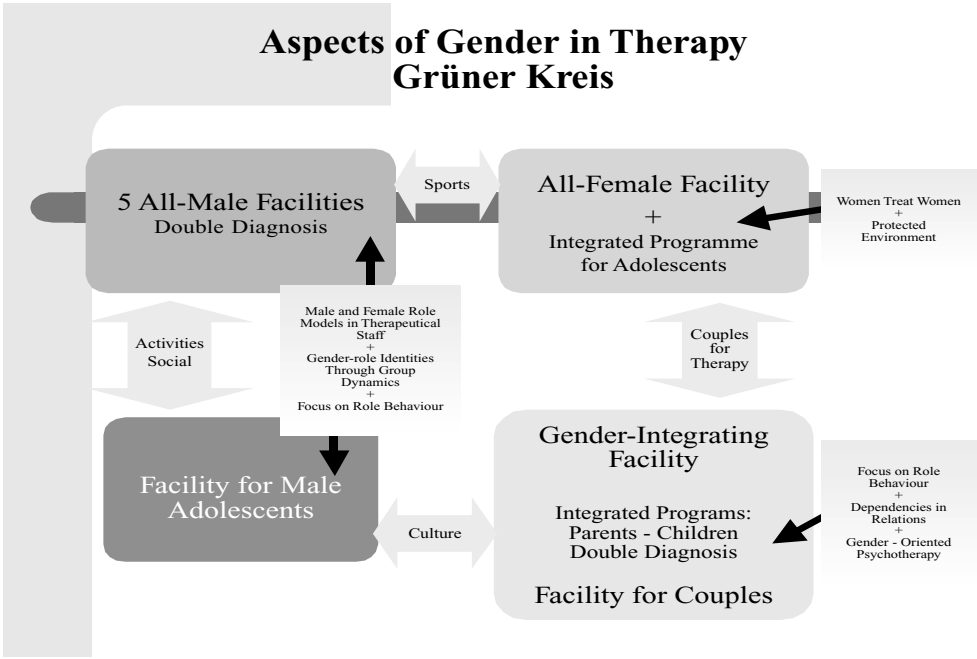
Implementing gender-oriented approaches in residential treatment does not even necessarily call for the need of installing special programmes, since gender-identity is such a pervasive component of the human psychological make-make up, it can be made to bear on all aspects of existing modes of therapy such as psychotherapy, self-help therapy or socio-therapy.

Following this review and formulation of demands on therapeutic communities, the structure of "Grüner Kreis", an Austrian provider of long-term residential drug therapy will be presented. Particular attention is paid to the way in which gender-oriented deliberations have gained access to the organisational structure of the institution on the one hand and therapeutical practice on the other. Finally, the perception of the relevance of gender-oriented aspects in therapy by patients currently in treatment at this institution, as established through focus-group research, completes this presenatation.

Diagram I below illustrates the various existing facilities at "Grüner Kreis".

DIAGRAM I

Within the organisational structure of Grüner Kreis an all-female facility with an integrated program for adolescents is maintained. In this context, the most important factor is that of the "protected environment". The majority of women in treatment have suffered from sexual abuse within their own family. This pattern is consequently



transferred to their role in the drug-community peer-group. Ensuing prostitution is a common phenomenon, as is abuse at the hands of their partners. In many cases there is therefore the imminent danger of a continuation of this pattern of dependency given the presence of male patients in the therapy setting. Sexual attractiveness and servility in cross-gender social relations might thus often be instrumentalised in an effort to (re-) gain self-esteem and a higher standing in the micro-social structure of the therapeutic community.

Within these facilities reserved for women exclusively, the idea of "women treating women" is considered as something like state-of-the-art in best practice. Therapeutical staff in these facilities therefore consists exclusively of women.

Individual cases where the deployment of a male therapist appears desirable, aid is however rather sought outside the therapeutic community by a therapist who is not involved in the structure and everyday life of the all-female community.

Given the pathological nature of these patients' dependency on relationships with men – an aspect which has been extensively covered in the relevant literature (- protection from potential dependencies is very much in the focus of attention. A key-concept in this pursuit is empowerment: Patients are provided direction on their path towards the construction of a new role-identity and a self-esteem that is not founded on dependency on others.

While his focus on protection is less instrumental in all-male facilities, the concept of discovering a new gender role-identity remains a key therapeutical concept. A

tendency of male patients to exert power over women (more often than not in a distinctly abusive fashion) is clearly observable. This common behavioural pattern of upholding a kind of larger-than-life "super-male" image often encodes a underlying defiant stance in the face of persistent fears of insignificance and sexual impotency. Equally hiding behind this mask are hints towards latent homosexuality. Extremely negative attitudes towards women on this level are however more often expressed secretly than voiced in public, i.e. in the social setting of the TC.

Approaches in a family-therapy setting involving this category of male patients have often yielded highly problematic and dependent relationships with their mothers, bordering on the abusive on the parent's side. To these men who are unable to maintain stable relationships with women, drug abuse serves as yet another substitute in their struggle to project a delusive image of masculinity.

The insistence on the importance of both male and female role-models within the therapeutical staff should thus become evident in the light of these findings. At least at an initial stage, these role-models can serve as veritable guide-lines for the individual patients in their quest for a new role-identity; particularly so in setting like therapeutic community which relies heavily on group dynamics. Consequently, the focus of the special "men's groups" in the facilities of "Grüner Kreis" is primarily directed towards role behaviour and relationships with women.

The institution's structure (cf. diagram I) is completed by a gender-integrating facility which also offers integrated programmes for parents with children and double-diagnosis patients. Within this setting shared residential facilities for couples are provided. With both men's and women's residences being located in close proximity to each other, limited social contact is enabled which is crucial for the social orientation of the children present. These children predominantly grew up with their mothers while the father was more or less absent from their lives.

The focus in treatment is on role behaviour, dependencies in relationships, gender-oriented psychotherapy, as well as therapy for couples and family therapy. Gender-oriented psychotherapy (particularly in concordance with socio-therapeutic measures applied) is a crucial factor in the establishment of a new role identity as illustrated above.

Generally there are no fundamental restrictions imposed on cross-gender contacts in the context of social, cultural and sports activities. Sexual relations are permitted following an initial period of six months, provided that the couples in question accept to pursue an accompanying therapy for couples, allowing them to reflect upon and freely discuss the behavioural patterns that are forming in their current relationship, offering guidance as well as providing crisis intervention.

This brief outline of the gender-integrating facility at "Marienhof" highlights the importance of gender-oriented approaches being inherent to all other therapeutical offers such as psychotherapy, self-help groups, counselling, as well as "alternative methods" or sports and cultural activities.

Aspects of Gender in Therapy Setting: "Marienhof"

Women	Women & Men	Men	Psychotheray
Womens Group	"Hausforum" (All Residents)	Group Psychotherapy	
Group Therapy Lineham Concep Double Diagnosis	Group Psychotherapy	Group Therapy Lineham Concep Double Diagnosis	
		Men's Group	

Aspects of Gender in Therapy Setting: "Marienhof"

Women	Women & Men	Men	Self-Help Groups Counselling
Theme-Centred Self-Help Group	Residential Groups	Theme-Centred Self-Help Group	
Counselling for Mothers	Parents' Supervision		

Aspects of Gender in Therapy Setting: "Marienhof"

Women	Women & Men	Men	Alternative Treatment
Sweat Lodge	Sweat Lodge		
Spiritual Drumming	Meditation		
	Yoga		

Aspects of Gender in Therapy Setting: "Marienhof"

Women	Women & Men	Men	Sports & Culture
Women's Running Group	Running Team	Football Team	
	Volleyball Team		
	Drama & Music Group		

An informal survey of therapists working at the "Grüner Kreis" as to their intentions for implementing gender-oriented programmes in therapy yields a fairly homogenous picture. The following table sums up the main line of argument.

Intentions of Therapists

- Deconstruction of Co -Dependency and Dependencies in Relationships.
- Providing an adquate environment for work on traumatic experiencies, such as sexual abuse and prostitution.
- Change of gender –identities related to the drug– scene.
- Creating an appropriate space for individuation.
- Systemic approaches: Role –models in a multi– generational perspective; Families.

It is furthermore revealing to compare this with the perception of gender-oriented work by the patients, as it arose from several focus-groups on this subject. Selected findings and statements shall now be shown.

The following questions were asked.

Focus Groups - Questions

I. Do you personally perceive any need for gender -oriented approaches in therapy. If so, what specifically should be done for women / men?

Focus Groups - Questions

II. To which extent are such approaches already applied at the Grüner Kreis and what remains to be done?

Focus Groups - Questions

III. How would a stronger emphasis on gender -specific issues affect your own success in therapy?

Below, the general tendency of responses to the individual questions are summed up and categorised according to male and female patients. These results are complemented by a selection of significant quotations.

Questions

I. Do you personally perceive any need for gender -oriented approaches in therapy. If so, what specifically should be done for women / men?

FEMALE PATIENTS - TENDENCY OF OPINIONS

- Gender -specific therapy groups are indispensable.
- Women feel more at ease among themselves when it comes to addressing issues like experiences of abuse.
- Women requiere specific therapeutic aid and couselling in dealing with their role as mothers in general and single mothers in particular.
- The individual perception of gender roles has to be questioned and modified.
- Women need distinct filds of work.
- Men and women should always be together in work therapy.

MALE PATIENTS - TENDENCY OF OPINIONS

- Perceive gender -specific approaches to be mainly relevant to women. Women have problems with men due to experiences of sexual abuse and prostitution and thus need therapeutic support in these particular questions.
- Men require female co –patients as a foil to their own lack of oppenness, reductance to display emotions and internal competition.
- Male patients need male role –models in therapy.
- Free choice of either male or female therapist.
- In work therapy, exclusively male domains should be preserved.
- Mixed –gender domains in work therapy are desirable.

Questions

II. To which extent are such approaches already applied at the Grüner Kreis and what remains to be done?

FEMALE PATIENTS - TENDENCY OF OPINIONS

- Women's concerns need more attention.
- More all –female groups.
- Mothers are in a privileged position when it comes to gender –oriented approaches.
- Existing offers are very important and serve their purpose well.
- Contacts to non –addicted women should be intensified.

MALE PATIENTS - TENDENCY OF OPINIONS

- There is a sufficient number of gender –specific initiatives.
- There ought to be more specific therapeutic offers of that kind. Groups should always comprise both men and women.
- Men are often being treated unfairly by therapists and have their masculinity put in a bad light.
- More support in dealing with co –depenency and relationship problems.

Questions

III. How would a stronger emphasis on gender –specific issues affect your own success in therapy?

FEMALE PATIENTS - TENDENCY OF OPINIONS

- Gender –oriented aspects crucial for success.
- Women have to develop new roles in their relations to men.

MALE PATIENTS - TENDENCY OF OPINIONS

- Learning to deal better with women is crucial for success in therapy.
- No influence whatsoever on progress in therapy.

FEMALE PATIENTS - STATEMENTS

- "Women should meet women from other TCs for an exchange of experiences".
- "Women must initiate common leisure activities, like all –female sport teams".
- "Classes in self –defence for women could be offered".
- "Women need classes in house –hold management and health –conscious cooking".

MALE PATIENTS - STATEMENTS

- "Emancipation has to be redefined. What might *male emancipation* look like?".
- "Certain images of masculinity, particularly that of the *cool and tough criminal* have to be questioned".
- "Typical sexual problems have to be made an issue in grups. The presence of women is important for the sake of greater openness".
- "Men are always assigned to role of aggressors,which needs to be change".
- "Men and women serve different roles in life. This has to be taken into account".

In general, these results show most heterogeneous and ambivalent reactions in both groups.

What becomes evident is that women perceive gender-oriented approaches to be much more important and relevant to their personal situation than men. We could observe a strong tendency towards establishing a "female movements" among women in therapy (meeting other women from outside a therapeutical setting or from other therapeutic communities, exchanging experiences, forming all-female sports teams, etc.).

Men, on the other hand, display great fear of being deprived of the presence of women (women are instrumental to their *own* openness in therapy, etc.). It is also interesting to see how men assign the role of solving problems of abuse or problems of a sexual nature exclusively to women ("something to be resolved among women in all-female groups"). This of course, presents a blatant denial of their very own problems and an effort to distract from the necessity of men working on their own inability to assume non-abusive relationships. The governing logic behind this line of thought seems to be a barely disguised: "If only the women worked more thoroughly on their problems in relationships, there would be no need for us to do likewise".

These results also indicate the need for wide-ranging efforts guaranteeing adequate therapy and counselling for women without reducing femininity to the function of motherhood.

The male-oriented and – dominated support system for addicts is called upon to effectuate some fundamental changes to its current structure. At the same time though, we have to re-consider the prevalent discourse on gender-oriented therapy (which should more rightfully be called "female-oriented"), to broaden its reach and to demonstrate its benefits for the male population as well.

While the integrative approach towards gender-oriented therapy as applied at the "Grüner Kreis" (as much room for improvements to these structures there admittedly is, however) might only be one of a myriad of possibilities to do justice to these imminent social demands with which professionals in the addiction field find themselves increasingly confronted, it can serve as an important stimulus for further discussions and developments. The IREFREA network provides the ideal forum for a discourse of this kind and can help bringing gender-related aspects in drug therapy to the attention of experts on a European level. This in turn will hopefully entail concerted efforts on a cross-national basis.

References

Björling B. (1997) *Intervention, prevention and treatment from a gender perspective. On the eve of a breakthrough*. In Council of Europe Ed, Symposium on Women and Drugs - Focus on Prevention (Bonn, 6-7 October 1995), Proceedings, Council of Europe Publishing, Strasbourg, pp. 99 - 106.

Copeland J Hall W. (1992a) *A comparison of women seeking drug and alcohol treatment in a specialist women's and two traditional mixed sex treatment services*. Client characteristics and treatment outcome, Drug Alcohol Dependence, 32, pp. 81 - 92.

Copeland J Hall W. (1992b) *A comparison of treatment drop-out of women seeking drugs and alcohol treatment.* In: a specialist women's and two traditional mixed-sex treatment services, *British Journal of Addiction,* 87, pp. 883 - 890.

Copeland J. (1997) *A qualitative study of barriers to formal treatment among women who self-managed change in addictive behaviour.* Journal of Substance Abuse Treatment, 14, pp. 183 - 190.

EMCDDA (1999) *Annual report on the state of the drugs problem in the European Union.* Office for Official Publications of the European Commission, Luxembourg. Also downloadable from the Centre's website www.emcdda.org

Ettorre B. (1992) *Women and Substance Use.* Routledge, London.

European Commission (1998) Directorate General V *Employment, Industrial Relations and Social Affairs, Directorate F - Public Health and Safety at Work*, *Prevention of Drug Dependence: European Networks.* Office for official publications of the European Communities, Luxembourg.

Fischer G. Schmidl-Mohl K. Etzersdorfer P. Schatten C. et al (1998) *Approaches to the management of pregnant drug misusers*. In Pompidou Group (ed) Symposium on Pregnancy and Drug Misuse (Strasbourg, 6-7March 1997), Proceedings, Council of Europe Publishing, Strasbourg, pp.15 - 26.

Gossop M. Griffiths P Strang J. (1994) *Sex differences in patterns of drug taking behaviour.* A study at a London Community Drug Team, *British Journal of Psychiatry*, 164, 101- 4.

Hedrich D. Rua dos Ferreiros E. (2000) *Problem drug use by women. Focus on community-based interventions.* Consultant study. Pompidou Group, Council of Europe. Strasbourg.

Hepburn M. (1996) *Drug use in pregnancy: sex, drugs, fact and fiction*, *Druglink.* July/August, pp. 2 - 4.

HLS - Hamburgische Landesstelle gegen die Suchtgefahren (1996) *Im Wandel und von Dauer. Bilanz und Perspektiven der frauenspezifischen Suchtarbeit.* Dokumentation einer Tagung der HLS und der NLS am 2.-3. November 1995. HLS, Hamburg.

Hodgins DC. Nady E and Addington J. (1997) *Treatment of substance abusers: single or mixed gender programmes.* Addiction, 92, pp. 805 - 812.

Hsu L - N. (1993) *Programme on Substance Abuse: Women and Substance Abuse: 1993 Country Assessment Report.* WHO/PSA/93.13. World Health Organization, Geneva.

James B. (1995) *Women, HIV and drugs services in four European Capitals.* European Addiction Research, 1, pp. 76 - 79.

Jarvis TJ. & Copeland J (1997) *Child sexual abuse as a predictor of psychiatric co-morbidity and its implications for drug and alcohol treatment.* Drug Alcohol Dependence, 49, 61 - 69.

Klee H. (1998) *Health care delivery during pregnancy* In: Pompidou Group (ed) Symposium on Pregnancy and Drug Misuse (Strasbourg, 6 - 7 March 1997), Proceedings, Council of Europe Publishing, Strasbourg, pp. 27 - 41.

Leopold B. & Steffan E. (1997) *Special needs of children of drug misusers - consultants' final report to the Pompidou Group* Council of Europe Publishing, Strasbourg.

Lewis S. Klee H. Jackson M. (1995) *Illicit drug users experience of pregnancy. An exploratory study* Journal of Reproductive and Infant Psychology, 13, pp. 219 - 227.

Lindebø Bjørg (1997) *Shared experiences-girl's groups: a method in HIV prevention* In Pompidou Group (ed), Symposium on Women and Drugs - Focus on Prevention (Bonn, 6-7 October 1995), Proceedings, Council of Europe Publishing, Strasbourg, pp. 113 - 118.

Merferth - Diete C. & Soltau R. (eds) (1984) *Frauen und Sucht. Die alltägliche Verstrickung in Abhängigkeit* Rowohlt, Reinbek bei Hamburg.

Olofsson M. (1998) *Consequences of drug use during pregnancy.* In Pompidou Group (ed) Symposium on Pregnancy and Drug Misuse (Strasbourg, 6 - 7 March 1997), Proceedings, Council of Europe Publishing, Strasbourg, pp. 9 - 14.

Pompidou Group (ed) (1993) *Symposium on Women and Drugs* (Gerzensee, Switzerland, 12-15 April 1988), Proceedings, Council of Europe, Strasbourg.

Roberts G. Ogborne A. Leigh G. & Adam L (1999) *Best Practices. Substance Abuse Treatment and Rehabilitation.* Health Canada, Office of Alcohol, Drugs and

Dependency Issues. Ottawa, Ontario. Also available under: <www.hc-sc.gc.ca/hppb/alcohol-otherdrugs>

Ruben S. (1995) *Women and drug use.* In Siney, C (ed) The Pregnant Drug Addict. Books for Midwives Press, Cheshire.

Siney C. (1995) *Management of pregnant women who are drug-dependent.* In Siney, C (ed), *The Pregnant Drug Addict,* Books for Midwives Press, Cheshire.

4. WOMEN, PREGNANCY AND METHADONE TREATMENT

By Françoise Facy, Myriam Rabaud, Marion Andry, INSERM XR. 302

1. The context of substitution therapy in France

In France, the prescription of substitution therapy for drug addicts has changed little since the seventies. For a long time methadone use was restricted to a small number of experimental centres. However, the late eighties brought a series of important revolutions to the field that saw the expansion of methadone prescription to all specialised treatment centres.

The current substitution policy in force since 1995 is built mainly on the use of two drugs that benefit from a specific marketing authorisation for the treatment of opiate drug addiction: methadone and Subutex®. Various treatment protocols exist and they differ according to the specific nature of places of treatment and whether or not they are specialised for drug-addicted patients. These forms of treatment form a care technique and integrate a global addiction therapy strategy.

1.1. The underlying principles

The aim of substitution therapy is to favour:

- the introduction into a therapy programme and an improvement in the medical follow-up of any addiction-associated psychiatric and/or somatic pathologies;
- a stabilisation of drug consumption from the illegal market (especially heroin) and a drop in intravenous assumption, which spread viruses and infection;
- re-introduction into society.

The ultimate aim of this kind of therapy is to allow each individual patient to build himself an addiction-free life.

1.2. Guidelines for methadone use:

Methadone

Following a period during which there was a gradual increase in prescription authorisation, since January 1995, all centres specialised in drug addiction counselling are permitted to prescribe and administer methadone. Since authorisation to market the drug, after an initial phase handled by a specialised centre, a rigorous system allows general practitioners to manage the therapy. This system requires all counselling centres

to have the staff (doctors and nurses) required to cope with this new form of counselling.

The initial treatment phase takes place in a specialised drug addiction counselling centre, where interdisciplinary teams operate. Urine tests are performed to establish addiction to opiates. Once the treatment programme is well under way it can be referred back to general practitioners.

With regards to pregnant women, recommendations usually prefer methadone to Subutex®, which has been in use for a shorter period of time (Wieviorka, 1994).

In order to assess treatment, an epidemiological study was conducted at Inserm (National Institute of Health and Medical Research) on 5 000 primary patients (Facy, 1999).

In the public health sector, assessment is aimed at achieving the following objectives:

- making a quantitative estimate of the groups of subjects treated;
- categorising the subject treated and comparing them with the drug addicts usually dealt with in the counselling system (specialised centres or penitentiaries);
- defining team work compared to professionals' networks and patients;
- investigating the existence of separate sub-groups in treatment follow-up.

The principle of a longitudinal study following the evolution of treated patients with regards to the level of their physical health, mental health and social re-introduction, has been terminated.

2. Aims and methods of the study

As with alcohol abuse, females are less frequently affected by drug addiction than males. In comparison with their male counterparts, they seem to experience greater difficulties in accessing counselling facilities than men and we can also observe a certain degree of alienation from this point of view; pregnancy and childbirth tend to increase their difficulties in contacting specialised drug addiction centres. Comparisons between female addicts screened in jail and those treated in counselling centres shows an increase in difficulties for drug addicted mothers and underlines the lack of follow-up by specialised teams available to them.

Within this kind of context, the encouragement of the prescription of methadone treatment to pregnant drug addicts should facilitate more global care, which in the long-run should allow the development of a satisfactory mother-child relationship.

The epidemiological data available (since 1995) allows us, on the one hand, to establish the situation of female drug addicts in specialised counselling centres and to compare them to women screened in jail, and to examine the specific situation of addicted mothers; and on the other hand, the study of pregnant women benefiting from methadone treatment shows the evolution of their health and their adaptation, thus

enabling us to assess the impact of a follow-up within specialised centres. The comparison of this data should allow us to make recommendations on screening, treatment and the follow up of female drug addicts, particularly during pregnancy.

3. The situation of female drug abusers in counselling structures

3.1. Comparison of women visited in counselling centres (n=1764) and in prison (n=183)

Social and family aspects

In prison, female drug abusers are far less numerous than in counselling centres, however they are twice the non drug-addicted female prisoner population. Foreigners make up 12% of the population and are therefore far more numerous than in counselling centres (5% on average).

52 % of the female drug abusers visited in prison were younger than 25 years of age and 21% older than thirty; in counselling centres, only 37% are under 25 and the average age is 27.

For 43% of the women in prison, accommodation is self-funded and very few subjects (10%) have no fixed abode, in counselling centres this figure was even lower (7%). The matrimonial status of female drug addicts in prison shows almost half to be unmarried, and 42% live with a partner: the notion of the stable couple is a little more frequent amongst female drug addicted prisoners. On the other hand, 44% of incarcerated female drug addicts are parents, which is a higher rate than that found in counselling centres (35%).

The family set-up of women prisoners is characterised by a higher likelihood of becoming drug abusers: 29% have a drug addicted brother or sister and 55% have an addicted partner.

Risks to the subject's health and immediate surroundings are therefore emphasised and cause further worries to the Public Health system concerning the transmission of HIV and infectious diseases such as hepatitis and tuberculosis.

Continuous occupation is rare (17%) and 49% of women prisoners have no professional qualifications.

The level of education received by subjects seeking treatment appears to be higher: 18% of specialised counselling centre "clients" has finished secondary or tertiary education and for this category, occupation is often intermittent (37%).

Therefore, the two groups of female drug abusers visited in prison or in counselling centres have very different socio-demographic characteristics: age, level of education, nationality and occupation. A certain number of selection effects are characteristic of imprisonment.

Legal aspects

Of the female drug abusers in prison, 64% are awaiting trial and 32% have been sentenced. 55% committed a drug-related crime. The crime is exclusively drug-related for 52% of cases, in direct relation with drugs for 24% and unrelated for 11% of crimes. 47% are hardened offenders. 43% were imprisoned for the first time before the age of 20. This therefore underlines the importance of delinquent behaviour and early judicial problems, which occurs before drug addiction in a considerable number of cases. 39% have already received a therapeutic order.

In specialised counselling centres, 20% of female drug abusers have been imprisoned, whereas this figure was double for men.

Medical aspects

Only 5% of drug addicted women visited in prison claimed to have never had an HIV test and 12% are HIV+.

In specialised centres, 56% had had a test. It has been estimated that the average prevalence of HIV among patients is 27%.

21% of imprisoned female addicts have had overdose problems, 24% have had viral hepatitis (B or C) (this figure drops to 18% for specialised centres). Mental health problems prove to be frequent amongst female drug abusers in prison: 37% have attempted suicide (28% in counselling centres, of which 1/5 prior to drug addiction). More than 1 woman in three has received psychiatric help (of which 1 in 5 prior to drug addiction).

These results appear to be minimal and the rather variable nature of responses suggests a very variable interest of the teams involved and an extremely heterogeneous awareness of patients' state of health.

Toxicological aspects

The majority of drug-addicted women use various products. For heroine users in specialised centres, addiction has an average duration of 7 years and total intoxication lasts an average of 10 years. These average duration times are slightly shorter for imprisoned heroine users, as the prison puts them into contact with counselling structures earlier. In the case of female inmates as opposed to treated women the products taken in association are heroine (90% vs. 68%), cannabis (34% vs. 38%), medicines (30% vs. 32%), cocaine (32% vs11%), alcohol (10% vs. 26%) and codeine (12% vs.25%).

The most frequently quoted starting product is cannabis (39% vs. 36%), followed by heroine (26% vs. 26%) and alcohol (6% vs. 7%).

The intoxication profiles of women visited in prison or in counselling centres are very similar with regards to the chronological progress between initial intoxication and addiction. Heroine is the most predominant product followed by cannabis.

Cannabis remains the most common starting product, however a considerable number of female drug abusers claim to have started with heroine.

3.2. Comparison between drug addicted mothers from counselling centres (n=613) and in prison (n=80)

It is much more common for female drug abusers to have children than for male drug addicts; in prison, drug addicted mothers are more common than in specialised or non-specialised health structures.

Drug-addicted mothers in prison also tend to have more children (34% have two or more) than those treated in counselling centres (30%). This can be linked to the fact that in prison drug addicted mothers are on average younger: 44% are under 25 years of age compared to 21% in counselling centres.

Social and family statistics

15% of all drug-addicted mothers in prison are foreigners (vs. 5%). 53% live in couples (vs. 39%). 51% have independent accommodation for the family (the same percentage was recorded in counselling centres) and 10% are without fixed abode (vs. 8%). Only 17% have a continuous occupation (vs. 12%) and half do not possess a professional qualification (vs. 28%). 58% of drug-addicted mothers in prison have an addicted partner and 39% have a brother or sister who is a drug abuser.

Medical statistics

3% of drug addicted mothers in prison have not had an HIV test (vs. 18%), the result is not specified for 21% (vs. 23%) and is positive for 8% (vs. 29%). 18% of convicted mothers has overdosed, 6% claim to have a sexually-transmitted disease. 24% have hepatitis (B or C) (vs. 22%) and 10% suffer from other disorders.

With regards to mental health, 40% have attempted suicide (vs. 30%), 38% have had psychiatric help (of which 1 in 6 prior to drug addiction). 30% have spent a period in a psychiatric hospital.

Judicial statistics

Two thirds of drug-addicted mothers in prison are awaiting trial. The crime is drug-related for one half and for 14% the crime committed was not drug-related, which demonstrates the role that screening drug abusers represents for the units in prison.

One half of mothers are hardened offenders, with the average age of imprisonment being 19. 48% have already received a therapeutic order.

Toxicological statistics

The majority of products used by drug-addicted mothers in prison are heroine (91% vs. 72%), cannabis (36% vs. 34%), cocaine (33% vs. 10%) and medicines (31% vs. 32%).

The most frequent starting product is cannabis (41% vs. 33%) followed by heroine (25% vs. 29%). Intoxication lasts more than 5 years for 4 drug-addicted mothers in five.

Follow - up in a counselling centre concerns less than one imprisoned mother in four, which demonstrates the lack of use of these structures by this category of the population.

By contrast, in counselling centres, more than half of drug addicted mother has had previous contacts with centres, 40% have already gone through withdrawal, however, relapses are frequent.

4. The evolution of pregnant drug addicts treated with methadone

In the survey conducted on a national scale in methadone prescription centres since 1995, a sample of 119 women who were pregnant at the start of treatment was analysed from their medical records and treatment follow-up (over a period of less than one year).

4.1. Initial situation

Toxological and medical observations

The main addiction product is heroin for 66% of those studied, for the remainder of patients 15% name Subutex®, 3 % methadone and 5 % codeine. Intravenous injections are (or were) practised by 70% of subjects. 21% also use cocaine, 4% codeine, 12% benzodiazepines, 4% Rohypnol® and 6 % alcohol. Starting products are cannabis (33 %), and heroine (45 %).

The average age of initial intoxication is 17.

54 % of subjects have been through institutional withdrawal prior to their joining the programme. The average number of withdrawals is 3. With regards to the difficulties encountered, 32% have overdosed, 40% have attempted suicide and 12% have had a physical trauma, 22% have had psychiatric care and 40% have resorted to the emergency services.

An HIV test is performed in 94% of cases and proves positive for 7% of patients; of which one quarter have fully-blown AIDS and only 38% follow specific treatment.

With regards to hepatitis, 21 % have hepatitis B and 52% hepatitis C. 10% has other types of infection. The non-response rates to these questions were fairly high, which shows a difficulty in establishing their health situation at the time of the admission medical report.

Previous experiences were frequent: 19% had previous medical experiences, 32% had past surgical history, 9% have a chronic illness and 56% mentions past obstetrics problems.

Of the treatments mentioned, 6% use anti-depressants, 4% tranquillisers and 30% other psychotropic substances.

Socio - demographic observations

Of total methadone prescriptions since 1995, 30% were female and 11% were pregnant women, which represents a rather large part. 43% of pregnant patients are single, 42% live in couples and 57% are already mothers.

Their family nucleus includes a partner (50%), children (32%), parents (37%) and 8% live in institutions.

49% have not obtained a secondary level of education (Lower Secondary School Certificate or Professional Aptitude Examination) and only 17% have a secondary school certificate or higher. 21% receive RMI Income Support and only 8% receive no social benefits at all. With regards to occupation, 7% are employed permanently and 38% have an intermittent job. 64% of those interviewed are employed.

For 7%, their occupation is the source of income, 53% mentioned aid; 13% have no source of income and 27% mentioned another source of income other than aid or work. 20% have an uncontrolled debt. 42% have at least one person dependant on them (often a child).

There are numerous problems on a legal level as 29% have been in prison. The median duration of prison sentences is 10 months and the average 18 months.

This pluralism of difficulties is also observed in pregnant drug abusers in other countries, such as the United States, where the socio-economic plan drawn up by Finnegan in 1995 recommends that this situation is resolved in order to avoid the risk of children being maltreated by their mothers.

Substitution observations

Of the pregnant women starting treatment, 38% had previously voluntarily participated in a substitution programme: 27% had received methadone and 46% had previously taken buprenorphine.

Various types of previous care initiatives were observed (withdrawal, substitution in clinic, participation in a methadone protocol) in programmes where relapses were numerous.

Of the 34 pregnant women who claim to have taken a substitute, 14% used codeine, 46% Temgesic (or Subutex®) and 7% other opiates.

At the end of the first month of methadone prescription, the average dose is 50 mg (median 58 mg) and on average there had been 5 visits to the centre per week.

On admission, the urine test is positive for methadone (20%), other opiates (69%) and other categories of drugs (39%).

Concerning the gravity of behaviour

Various visual gauges, which are scaled from 1 to 7, are used to measure prevention attitudes (risk of infection from blood or sexual behaviour), psychological problems and anxiety, delinquency and dissatisfaction of family and social relations.

Average scores for prevention attitudes and the risk of contamination from blood or sexual relations are between 2 and 3.

Psychological statistics show:

• anxiety : average score 3;

• depression : average score 3;

• psychotic problems: average score 1;

• behavioural problems: average score 2;

Levels of dissatisfaction with regards family and social relations have an average score of 4 and 3 respectively. Average gravity is 2 with regards to delinquency.

4.2. Analysis of the treatment follow-up

Attendance of the initial prescription centre

According to the information available to Inserm in June 2001, 29% of the 119 women studied left the centre after one month, 37% were followed for less than six months and 34% were treated from 6 months to one year. 6% changed centre and 2% were transferred to their general practitioner. 2 patients died.

Characteristics of treatment at the last report

For two thirds of patients, methadone treatment lasted between 4 and 12 months. The retention rate appears to be fairly good, considering the numerous difficulties accessing care and the reluctance to consultation for pregnant women (Picard, 1995).

The average methadone dose is 58mg (median 60 mg). The average number of visits per week is 3. The average number of monthly consultations is 2.

Dosage is dealt with by several authors, as is the daily intake fraction (Jarvis, 1999), the period of prescription (within the first three months of pregnancy for Depetrillo, 1995), and the use of low dosage (Offidani, 1986).

Care programmes associating methadone and psycho-social counselling are much more frequent for pregnant addicts than for treated abusers in general. The interest of inter-disciplinary intervention is highlighted by other studies conducted in Belgium (Picard, 1995), of an « improved treatment » in the United States (Chang, 1992) and of pregnancy management based on European Experiences (Cahiers T3E, 1997). The need for adequate policies is emphasised by Mc Lean (1994).

Therefore methadone doses during pregnancy have increased in line with a reduction in consultations. Psychotherapeutic support concerns 46% of patients. Socio-educational follow-up is given to 67% of pregnant subjects, which is much more than for other addict categories.

Associated therapy included anti-depressants (9%), tranquillisers (5%), other psychotropic drugs (35%), which was considerably higher than at the start of therapy.

The evolution of pregnant women with regards to the substances used

Drug use is not systematically recorded during care, however the following products were mentioned:

	Habitual use (%)	*Intermittent use (%)*	*Occasional use (%)*
Cocaine	7	-	14
Alcohol	4	4	29
Opiates	6	3	55
Benzodiazepines	30	10	10
Other substances	9	4	26

The evolution of substance usage shows a considerable drop in opiate use. The largest increase concerns alcohol, which is used by 38% of subjects and the benzodiazepines used by 50%, which is the same value as that recorded for addicts under methadone therapy in general.

Other studies confirm these trends concerning consumption associated with methadone in Australia (Fischer, 1999); the drop in opiate use is observed by Boer (1994) in Holland and Batey (1993) in Australia.

The state of health

Events that took place during care were:

- suicide attempts 2 %;
- overdoses 1 %;
- accidents 2 %;
- traumas 1 %;
- psychiatric hospitalisation 6 %;
- emergency aid 6 %.

The known infectious state showed that 96% had performed a HIV test, 7% were HIV+ of whom 13% have AIDS. **Half of all pregnant HIV+ patients receive special treatment, which is more frequent than at the start of treatment.**

Last report shows an increase in hepatitis, 26% have or have had hepatitis B and 54% hepatitis C.

Obstetric difficulties are observed for 84% of patients, the increase (28%) since the start of treatment shows that pregnancies can often be difficult for this category.

Social situation and psychological evolution

The source of income shows improvements, however 10% remain without income. The accommodation situation is extremely precarious for 3% of cases.

The family nucleus remains important, however there is a drop in the presence of partners (present in 45% of cases) and parents (present in 31% of cases).

Behavioural and psychopathological gauges show no change in the average values recorded, which contrasts with results for other categories of patients that usually show considerable improvements in averages. These are more rapid with regards to attitudes and relations and slower with regards to the patients' psychological state. However, these gauges usually show medium or low gravity and methadone therapy enables these levels to be maintained and situations to be stabilised.

Conclusion

Epidemiological studies on addicted women receiving care in specialised centres or screened in prison enable us to make a series of observations:

- drug addiction remains less common in women than in men, however the gravity of their addiction differs and they start using heroin more rapidly and more frequently consume more than one substance, mainly medicines;
- women screened in prison often fail to use counselling facilities and are often not provided with specialised care; they encounter a whole range of problems and the addicted mother category is further characterised by precarious health and relational problems;
- pregnant women are particularly prone to several risks; they have often had past obstetrics problems or previous problems during pregnancy, revealed by methadone therapy and medico-psycho-social care;
- the evaluation of methadone prescriptions with follow-up in a specialised centre during pregnancy does not on average lead to a rapid improvement in psychological difficulties and social and family reintroduction. However, the stabilisation of the patients' psychological and relational state has been observed, when the pregnancy period could be expected to worsen the situation;
- as with other categories treated with methadone, there are doubts as to the ideal duration of treatment and certain experts claim that efficiency is obtained after 3 years. In the case of pregnant women, the efficiency of substitution therapy should take into account the evolution of the unborn child and his psycho-motorial and affective development.
- as with other categories of patients treated, a rapid drop in the use of heroine and opiates is observed; it should be noted that an increase in the dose of methadone after the first month of treatment is accompanied by an increase in other psychotropic drug treatment;
- statistics on the family nucleus show a fragility in relations, with a high number of dissatisfactions for many pregnant patients and separations in the family for a large number. This data shows the need for careful care with regards to both the health and the relational aspects;

- difficulties and reluctance in accepting specialised care are particularly acute with pregnant women, and screening and counselling should be reinforced in structures in penitentiaries and in the community in general.

References

Batey R. G. Weissel K. (1993) *A 40 month follow-up of pregnant drug using women treated at Westmead Hospital. Drug and Alcohol Review,* 12, pp. 265 - 270.

Boer K. Smit B.J. Van Huis A.M. Hogerzeil H.V. (1994) *Substance abuse in pregnancy: do we can? Acta paediatrica Scandinava,* Supplément, 404, pp. 65 - 71.

Chang G. Carroll K.M. Behr H.M. Kosten T.R. (1992) *Improving treatment outcome in pregnant opiate-dependent women. Journal of substance Abuse Treatment,* 9, pp. 327 - 330.

Depetrillo P. Rice J. M. (1995) *Methadone dosing and pregnancy: impact on program compliance. International Journal of the Addictions,* 30, (2), pp. 207 - 217.

Facy F. (1999) *Toxicomanes et prescription de méthadone.* Paris, EDK, p. 128.

Finnegan L. P. (1995) *Addiction and pregnancy : maternal and child issues.* In: Tagliamonte A., Maremmani I., Drug addiction and related clinical problems, New-York, Springer-Verlag Wien, pp. 137 - 147.

Fischer G. Jagsch R. Eder H. Gombas W. Etzersdorfer P. Schmidl-Mohl C., Schatten C. Weninger M. Aschauer H.N. (1999) *Comparison of methadone and slow-release morphine maintenance in pregnant addicts.* Addiction, 94 (2), pp. 231 - 239.

Jarvis M. A. E. Wu - Pong S. Kniseley J. S. Schnoll S. H. (1999) *Alterations in methadone metabolism during late pregnancy. Journal of Addictive Diseases,* 18, (4), pp. 51 - 61.

Mc Lean A. (1994) *«The little people therapeutic project» - Ethique et valeurs idéologiques à propos de quatre années de travail aux Etats-Unis de 1987 à 1991.* Information Psychiatrique, 70 (2), pp. 163 - 171.

Offidani C. Chiarotti M. De Giovanni N. Falasconi A.M. (1986) *Methadone in pregnancy: clinical, toxicological aspects.* Clin Toxicol, 24, pp. 295 - 303.

Picard E. (1995) *Méthadone and pregnancy.* Archives of public health, 53, (5 - 6), pp. 183 - 205.

T3E (1997) *Les traitements de substitution en Europe.* Cahiers T3E, (2), p. 189.

Wieviorka S. (1994) *Grossesse et toxicomanie : une multiplicité des risques.* Revue du Praticien, 8, (247), pp. 37 - 41.

ANNEX

Women pregnant on admission

(under methadone – less than 12 months)

N = 119		**Initial test**	**Current state at < 12 months methadone therapy**
Nationality	French	93 %	
	Foreign	6 %	
	Not stated	< 1 %	
Family situation	single	43 %	
	open relationship	37 %	
	married	5 %	
	widowed	3 %	
	separated	10 %	
Education received	primary	8 %	
	secondary/BEPC	24 %	
	technical/CAP	17 %	
	second/2nd cycle	11 %	
	technique/BEP	23 %	
	General Bacc.	12 %	
	Technical bacc.	< 1 %	
	Bacc. + 3 ou >	4 %	
No. of children	2and more	21 %	
	1	36 %	
	none	30 %	
	No answer	13 %	
Social benefit currently received	Income support	21 %	19 %
	none	8 %	6 %
	Personal support	4 %	4 %
	Other support	67 %	71 %
Current age	average	32 years old	
	[ampl.]	[19-44]	
Months on methadone		3.4 months [0-11]	

N = 119		**Initial test**	**Current state at < 12 months methadone therapy**
Duration of methadone treatment in months	1 [1 - 5] 6 - 11	29 % 37 % 34 %	29 % 37 % 34 %
Most recent primary substance	**heroin** Subutex codeine cocaine Temgesic methadone	**66 %** 15 % 5 % 3 % < 1 % 3 %	
Starting age for primary substance	average [ampl.]	21 years old [12-37]	
Secondary substance 1	cannabis cocaine Benzodiazepine heroine codeine alcohol Rohypnol	26 % 21 % 12 % 12 % 4 % 6 % 4 %	
Intra-venous injection	**Yes-currently** Yes-in the past	**39 %** 31 %	

N = 119		Initial check	Current state
Starting substance	heroine cannabis	45 % 33 %	
Starting age for starting substance	average	17 years old	
Previous institutional withdrawal	yes	54 %	
No. of institutional withdrawals	average	3	
Risk of blood contamination	average [ampl.]	2 [1-7]	2 [0-7] (current)
Risk of sexual contamination	average[ampl.]	3 [1-7]	2 [0-7] (current)
Depression gauge	average [ampl.]	3 [1-7]	3 [1-6] (current)
Anxiety gauge	average [ampl.]	3 [1-7]	3 [1-7] (current)
Behavioural troubles gauge	average [ampl.]	2 [1-7]	2 [1-6] (current)
Psychotic trouble	average [ampl.]	1 [1-7]	1 [1-7] (current)
Anti-depressant psychotropic drug therapy	yes	6 %	9 %
Tranquilliser psychotropic drug therapy	yes	4 %	5 %
Other psychotropic drug therapy	yes	30 %	35 %
Suicide attempt	**yes**	**40 %**	2 % (since admission)
Overdose	yes	32 %	< 1 % (since admission)

N = 119		Initial check	Current state
Physical trauma	yes	12 %	< 1 % (since admission)
Psychiatric hospitalisation	yes	22 %	6 % (since admission)
Emergency aid	yes	40 %	6 % (since admission)
HIV test	yes	94 %	96 %
Result of HIV test if performed	**positive** Awaiting result	**7 %** < 1 %	**7 %** < 1 %
If positive, HIV infection	Asymptomatic form. Fully-blown AIDS.	50 % 13 %	63 % 13 %
Fully blown AIDS	**25 %**	**13 %**	
If test positive, specific treatment	yes **no**	38 % **50 %**	**50 %** 38 %
If test positive, follow-up	regular **irregular** unknown	63 % **25 %** 13 %	75 % 13 % 13 %
Viral hepatitis B or C	Yes currently Yes in the past **Not tested**	25 % 7 % **7 %**	**43 %** 5 % 5 %
Hepatitis B	Yes, currently Yes, in the past **no** Not tested	7 % 14 % 68 % 2 %	12 % 14 % 66 % 2 %

N = 119		Initial check	Current state
Hepatitis C	Yes, currently	43 %	48 %
	Yes, in the past	9 %	6 %
	no	41 %	40 %
	Not tested	2 %	2 %
Tuberculosis currently	yes	0 %	0 %
Other infections	yes	10 %	10 %
Chronic illness	yes	9 %	10 %
Past medical incidents	yes	19 %	21 %
Past surgical incidents	yes	32 %	32 %
Past obstetrical incidents	yes	56 %	**84 %**
Accommodation	Self-financed	50 %	63 %
	With parents	6 %	3 %
	With a third party	12 %	9 %
	independent	4 %	5 %
	No fixed abode	**6 %**	**3 %**
	In a shelter	11 %	8 %
Professional qualification	yes	47 %	48 %
Professional activity	continuous	7 %	7 %
	None/never	25 %	26 %
	intermittent	38 %	37 %
	interrupted	16 %	16 %
Social status category	employee	20 %	20 %
	Admin. worker	15 %	15 %
	Sales worker	29 %	29 %
	Health/social	6 %	5 %
	unemployed	2 %	2 %
	prostitute	0 %	0 %

N = 119		Initial check	Current state
Current source of income	Aid only	53 %	52 %
	No source of income	**13 %**	**10 %**
	Occupation only	7 %	8 %
	other	27 %	30 %
No. persons dependent on subject	0	58 %	
	1	31 %	1 [0-3]
	2 or more	11 %	
Debt	controlled	19 %	20 %
	Not controlled	20 %	20 %
	none	62 %	61 %
Imprisonment	yes	29 %	-
Total duration of prison sentence (n=35)	average	18	-
	median	10	
Gravity of delinquent behaviour	average [ampl.]	2 [1-7]	2 [0-7]
Stable family nucleus partner	yes	50 %	45 %
children	yes	32 %	40 %

N = 119			Initial check	Current state
Stable family nucleus	parents	yes	37 %	31 %
	family	yes	23 %	22 %
	friends	yes	33 %	31%
	alone	yes	9 %	8 %
	institution	yes	8 %	9 %
Family dissatisfaction gauge		average [ampl.]	4 [1-7]	4 [1-7]
Social dissatisfaction gauge		Average [ampl.]	3 [1-7]	3 [1-7]
At the end of 1st month		In last 3 months	20 %	-
Methadone dose		In the past	7 %	-
		no	**73 %**	-
Buprenorphine dose		In last three months	27 %	-
		In the past	19 %	-
		no	54 %	-
Dose of another substitution substance		In the last three months	23 %	-
		In the past	8 %	-
		no	69 %	-
Introduced in a substitution protocol		yes	38 % (n = 40)	-
Taking a product aimed at substitution		yes	34 % (n =34)	-
Substitution product used		Subutex	46 %	
		codeine	14 %	
		Temgesic	7 %	
		methadone	14 %	
		Other opiates	7 %	
Dose of methadone		average [ampl.]	50 [10-130]	58 [25-100]
		median	45	55
No of visits per week		average	5	3
		median	5	2

N = 119		Initial check	Current state
Urine test positive for methadone	yes	20 %	-
Urine test positive for another opiate	yes	69 %	-
Urine test positive for another substance	yes	39 %	-
Abandoned protocol	yes of which for medical reasons	- -	49 % (n= 58) 20 % (n=11)
Transferred to general practitioner	yes	-	2 % (n = 2)
Change of centre	yes (n=7)	-	6 %
No. of current visits per week	average	-	3
Frequency of consultations per month	average	-	2
Psychiatric support	yes	-	46 %

N = 119		Initial check	Current state
Social-educational follow-up	yes	-	67 %

5. DRUGS, FEMALE CRIMINALITY AND DETENTION IN EUROPE

By Laura De Fazio

When facing the subject of drug addiction due to its many implications, one of the most problematic and important aspects is, without a doubt, the relationship between drugs and criminality (Carrieri, Catanesi, 1999; Ponti, 1999; Merzagora Betsos, 2001).

Indeed, taking into consideration the complexity of the problem, it is well-known how such a co-relation can be examined from different points of view, that have however, been tackled in simplistic and arbitrary terms more than once.

With this in mind, it has been underlined how the empirical study of the connections between drugs and criminality must not ignore the subtle distinction, primarily differentiating its hypothesis according to which drug addiction is considered equivalent to criminal behaviour, since according to the legislation of many countries it corresponds to a crime, and those cases in which the two modes of behaviour (drug addiction and criminality) are associated in the same subject and involve other subjects.

Indeed, drug abuse leads to crimes that differ greatly from one another and that can be outlined as follows:

1. those concerning criminality that is directly linked to the production and the distribution of the drug cycle and that are committed by subjects who are not generally involved in drugs, with the exception of the small dealer;
2. those committed by people under the influence of drugs, either in an acute, habitual or chronic state of intoxication;
3. those committed with the aim of finding the money necessary to maintain their drug addiction.

In the first hypothesis the drug addict, even if he is often also a drug peddler, takes on the predominant characteristics of a victim rather than the author of the crime. This is due to the position of clear dependence on not only the substance but also on those who are able to get hold of it for him. He often becomes the victim of bribery, aggression and increasingly of murder.

A separate problem is, however, that of the phenomena of contemporary induction to the use of drugs and to committing crimes by adults towards the young.

It would therefore appear that the first hypothesis reveals a main area of criminality concerning the crimes committed at the cost of those who use drugs. The majority of these crimes are not brought to justice since the victims do not report them.

The second hypothesis concerning crimes committed under the effect of drugs is the one that should involve the relationship drugs-criminality to a greater extent at a conceptual level. This hypothesis concerns criminality that could be called ìdirectî, or rather involves the bio-chemical and psycho-pharmaceutical characteristics of drugs (above all the parasympathetic-mimetic characteristics), which activate mechanisms of aggressiveness and diminish the capacity of control and criticism.

However, in reality this hypothesis is the one that arouses the least interest at a social and criminal political level since the numbers involved are modest, and are certainly lower than those that exist in the relationship between drugs and criminality, and above all, because it raises problems for the evaluation of penal responsibility.

The third hypothesis, or rather the one regarding the crimes committed by drug addicts to obtain the means necessary to keep up their drug addiction, even if it can be characterised as indirect criminality, is the one that interests us the most due to the quantitative characteristics of the phenomena and the social alarm it creates.

In relation to this problem it can be observed how the research that concentrates on the impact between the social-legal systems and the interactive behaviour between drug abuse and criminality, or on the study of prevention systems, of treatment and rehabilitation in the various European countries, all reveal that the links between drug abuse and criminal behaviour in the same subject are undoubtedly very strong and provide us with high percentages for criminal behaviour in drug addicted subjects (Ponti, 1999).

Such an approach takes on a specific interest if it is examined in relation to the identity of gender, from the very moment that one speaks of both drug addiction and delinquency in reference to the female sex, both of which have been observed as specific quantitative and qualitative aspects with respect to the same phenomena in the male sex (De Cataldo Neuburger, 1996; Ponti, 1999).

In particular, apart from the specific elements that characterise female drug addictions (see: Stocco, Llopis Llacer, De Fazio, Calafat, Mendez, 2000), and apart from the aspects highlighted by numerous authors concerning female delinquency (De Cataldo Neuburger, 1996; Ponti, 1999), it should also be underlined how the relationship between drugs and criminality, while it does not completely differ from the terms outlined above, still recognises characteristics that are of considerable interest when, as often happens in the lives of many drug addicts, the female drug addict and perpetrator of a crime, not only experiences imprisonment but also has underage children.

Indeed, apart from noting the consolidation of the minor contribution of the female sex to delinquency and in relation to the percentage of detention that, despite fluctuations, always shows a limited percentage of female inmates, for example in Italy more than a 1/3 are drug addicts, percentages are much higher when compared to their male counterparts.

For example, the statistics from the Italian Ministry of Justice for the year 1995 reveal a female presence in Italian prisons of 4.55% of whom 37.74% are drug addicts. In the same period the figure for male drug addicts is 29.11%. 1.94% of these women are mothers living in prison with their respective children. For the previous year the official

statistics for international and European comparisons reveal higher percentages of women inmates in Spain (9.61%), Portugal (7.79%), Hungary (5.68%), Denmark (5.37%), Belgium (5.23%) (Marinari, 1996).

The official statistics available from the Ministry of Justice on June 30th 2000 are for a total of 53,340 inmates in Italian penitentiary institutions of which 2,266 (4.2%) are women. During the same period there are 14, 602 drug addicts, or rather 27.3% of the total of the inmate population of which 676 are women (29.8% of the female population and 4.6% of the population of drug addicts) (www.giustizia.it).

As regards the female population in penitentiaries some authors have noted a progressive increase in the number of women imprisoned for crimes connected to drugs, frequently with problems of drug addiction as well as coming from family backgrounds with multiple problems and often with relationships with subjects who are also often in prison due to drug problems.

Sometimes, and more and more frequently the female inmate population in Italy includes the presence of foreign women who have been used to carry drugs and who have neither problems of drug addiction nor previous convictions.

In both cases, whether Italian or foreigners, this underlines the central role of drugs in the process of the criminalisation of these women (Eurispes, 1998).

As regards the scarce female tendency to commit crimes, this literature shows how the women in general are very rarely the perpetrators of serious crimes and/or of crimes against another person. An Italian national survey reveals (Eurispes, 1998) that the crimes with the highest proportion of female sentences are those concerning the economy or public faith, while for the other types of crime typology those that are characterised by a greater importance at a quantitative level are those linked to the production, the sale and purchase of drugs.

Overall, the statistics available for the situation in Italy show how the clearest characteristics of female crime in Italy over the last years are those from the predominant presence of young subjects, between 25 and 44 years old, with a considerably low level of education, mostly single, unemployed or housewives and rarely self-employed. Sometimes there are old offenders and mostly with sentences for crimes that represent a low level of danger to society (Eurispes, 1998).

As has already been said, the phenomena of the criminality of female drug addicts with all its characteristics that are co-related to both female delinquency and female drug addiction, involves imprisonment of the latter, a problem that requires specific space for reflection.

In Europe, the OEDT states that between 15 and 50% of the inmates in the European Union have, or have had problems with drugs and that the over-crowding in the institutes very often hinders assistance for the drug addicts, a problem that is made worse by the lack of a suitable training of the penitentiary staff (OEDT, 1999).

What is more, it is impossible not to see how the concentration of drug addicts in prison is much higher with respect to the general population, with all its correlated problems that

are obviously magnified by the characteristics of the institution, above all as far as the women are concerned since, apart from some rare exceptions and until recently, the penitentiary institutions were based on the model for males (De Fazio, Luzzago, 2000).

Indeed, there is no doubt that the experiences such as criminality and detention that are often part of female drug addictsí past, have specific relapses in different surroundings, above all in the presence of a partner who is also a drug addict and/or has legal problems (a relatively frequent situation); relationships with their family and children, health and above all pregnancy and maternity and, finally, the treatment itself (Stocco. Llopis Lllacer, De Fazio, Calafat, Mendez, 2000).

It is certainly a very complex and detailed subject that involves different levels of both analysis and intervention, starting with the typical legal situation and leading to other more specific levels concerning the treatment inside and outside the penitentiary.

As far as the penal system is concerned, it can be observed how most countries have a system which adopts the principle of treatment instead of punishment, with a choice that is obligatory to various degrees depending on the country.

Concerning the imprisonment itself, it can be seen how, on the one hand it is a male phenomena, and on the other, whether it is precisely the presence of a female in prison that presents different problems that are co-related to the characteristics of the female condition that become even more evident in a context with rules and structures that are based on typically male characteristics.

Without a doubt the most important characteristic is that concerning the affective-family sphere, which can present aspects of a considerable dramatic nature for female inmates, above all where their children are concerned.

In the past the subject of the maternity of female drug addicts has already been analysed and all aspects of the problem were highlighted, also in relation to the treatment (Malagoli Togliatti, 1993).

Reading at a European and international level has, indeed, underlined how the decision for female drug addicts to undergo treatment is linked to the presence of their children and their fear of losing them (Rosenbaum, 1997).

Another element that is of fundamental importance is that of the choice of treatment as an alternative to penal sanctions ensuing a crime committed by the drug addict.

As regards the condition of the women inmates in Europe it has been observed that overall, their imprisonment is generally very short, taking into consideration, as has already been noted, the fact that their crimes they committed were not very serious; also, if there are children, norms exist reducing the stay in prison so that the family situation suffers as little as possible.

From this point of view one can see the significance of the subject in relation to the importance of the individuation of a treatment programme for female drug addict inmates, taking into consideration the fact that very often it is not easy to determine the one that is most suitable to the individual case, not only in relation to the characteristics of the female

conditions, but precisely due to the mother-child relationship. This leads to the importance of the existence and awareness of specific programmes such as those for the mother-child community that IREFREA research has developed in each country.

In European and international literature not only are there few studies on the relationship between maternity and drug addiction, but also between maternity and prison, and it is only in the last few years that greater attention has been paid to this specific problem, also in relation to the possible repercussions for the children. These studies mainly deal with the problems of children who live in prison with their mothers, but obviously the subject is also extended to the importance and consequences of separation between mother and child in prison (Biondi, Daga, 1989; Campelli, Faccioli, Giordano, Pitch, 1992; Luzzago, Bolognesi, De Fazio, Donini, Pietralunga, 2001).

At the moment we do not have any statistics that evaluate the number of inmate mothers and inmate mothers with problems of drug addiction at a European level, only certain data that refers to mothers who have their children in prison with them.

A report of the Howard League for Penal Reforms based on the data that there are 100,000 women in penitentiary institutions in Europe, estimates that around 10,000 infants or children under 2 find themselves in this situation (2000).

Whereas in Italy the data available indicates the presence of 46 children in Italian prisons, another study in France states that around 50 children under the age of 18 months enter French prisons each year.

An English study (Caddle, 1998) reveals the presence of a large number of mothers with children in prisons, for the majority of whom there is no other choice but to look after their child themselves, and according to the author, the same is presumably happening in other European countries.

While in Canada and the United States no prison allows an extended stay of children with their mothers, the situation in Europe presents variations according to the different countries, even if the mothers are generally allowed to keep their children with them, but only for a limited age limit that varies from country to country (Bertrand, 1998).

In Sweden the prevailing principle is that children must not live in a penitentiary environment, thus, while they can stay there up to the age of one, and for an average period of not more than three months, they hardly ever spend periods of time inside a penitentiary institution.

In Spain and Germany, female inmates with children are allowed to keep their children with them in prison up to the age of 6, an age limit that goes down to 3 in Germany when a closed institution is involved.

In Italy, Portugal, Switzerland and Denmark the age limit goes up to 3, with the characteristic for the latter that the child can be not only with the mother, but also the father.

In France the law foresees that the female inmate with child can keep them with her up to the age of 18 months, and the same age limit can be found in England and Wales, although in some institutions this is only for infants up to the age of 9 months.

In Belgium, although there are no penitentiary regulations regarding the age limit for allowing a child to stay with its mother in prison, in practice it is allowed up to the age of 18 months, and in some cases up to the age of 2.

In the Netherlands, depending on the type of institution, the age limit is between 9 months and 4 years.

The Council of Europe has also intervened with more than one recommendation concerning the subject of mothers and their children in prison, and in 1989 a Resolution adopted by the European parliament recognised female inmates as a specific category requiring special protection, inviting the member states to draw up policies that were an alternative to detention.

On the other hand, for some time it has been observed that there are no doubts regarding the negative effects that detention has on children, either experienced in first person or due to the absence of their mother figure, and that the childís interest is to be considered a priority, also in view of the fact that the statistics indicate a low percentage of women in prison for serious or dangerous crimes.

On the basis of such considerations, in a Commission Report, the Council of Europe recently suggested social, health and family issues, the creation of small, closed or semi-closed detention units by the member states, which should be used as for those cases in which imprisonment is considered indispensable for the women, and at the same time the use of alternative punishment in the majority of the cases.

These affirmations are completely confirmed in international sources of the UNO Convention of childrenís rights (art. 2,3), in the European Convention of the Rights of Man (art. 8) and in the 1987 European penitentiary Regulations in which it can clearly be seen how a compulsory separation of a mother from her child is to be considered a violation of international law.

Furthermore, all those who have reported the difficult situation of ìchild inmatesî or of children separated from their mothers due to their detention have underlined that in most cases the women imprisoned in Europe have been sentenced because of minor crimes and/or crimes that do not represent a danger to society (Bertrand, 1998).

On this subject it has been observed in both Europe and the United States that there are very few specific projects and penitentiary set-ups of an experimental nature that try to take into consideration the specific needs of female inmates with children, and above all, of the children with them, from the point of view of reducing all the problems that imprisonment entails and that can seriously interfere with a childís normal development.

In Paris, France there is the experiment ìRelais Enfants ñ Parentsî while Germany offers an open penitentiary unit that of Frondenberg, situated outside the prison walls with apartments for the mothers. In Italy, however, there are few pilot experiments and they are mainly led by voluntary groups such as the Milan group ìBambini senza sbarreî. They owe their experimentation to the sensitivity of the individual prison administrations and Magistracies as well as some penitentiary workers.

From a legislative point of view, in Italy the recent law of March 8, 2001 ìAlternative measures to detention to protect the relationship between female inmates and minorsî, states that the stay of children in prisons should be almost completely avoided taking into consideration the forecast of instruments that will permit many women who have been sentenced to avoid detention.

Other countries such as Spain, Holland and Germany also foresee alternative measures to detention or ìopen-typeî institutions for mothers with small children.

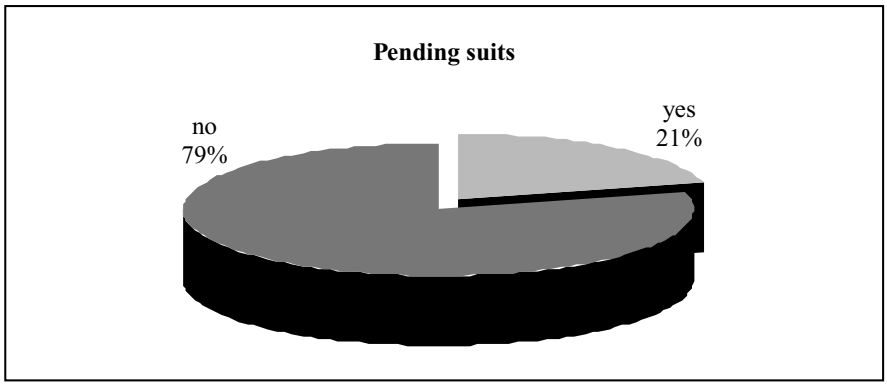
Until now, the problem in question presents a specific and relevant interest since any plan and arrangement for interventions regarding this phenomena must take into consideration the data and conditions of the female inmate population. And at the moment, the data and conditions of the latter indicate not only an increasing presence of female immigrants but also a high percentage of drug addicts who have already been imprisoned and who have family histories that are often extremely problematic.

This situation therefore requires the involvement of all institutional and extra-institutional subjects involved in such situations, as well as the adoption of political and operative choices that not only concern legislation but also the organisation and penitentiary staff, the network of territorial services including those who deal with drug addiction.

On this subject some of the data from the IREFREA study on female drug addiction in Europe is of considerable interest (refer to this for a more comprehensive understanding of the subject)ñ that limited to the legal and penitentiary sphere concerning 340 female drug addicts ñ with and without children ñ undergoing treatment and interviewed as part of the study.

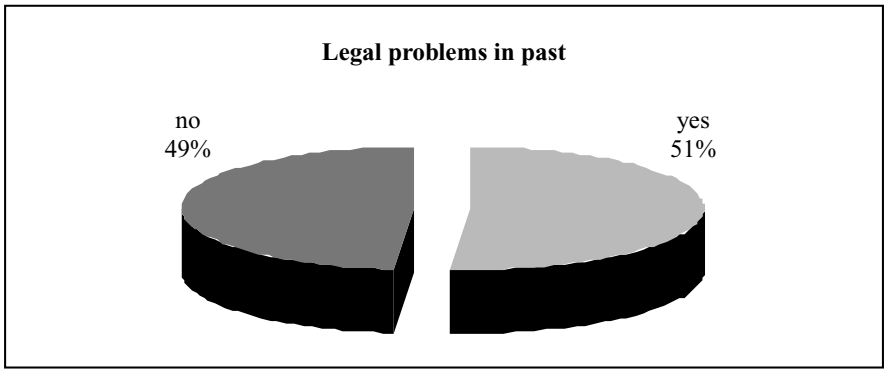
When interviewed, the majority said they did not have penal suits pending (79%), a comprehensible element in the light of the fact that they had already been undergoing treatment for some time at the time of the questionnaire.

Current pending suits (% of total answers given)



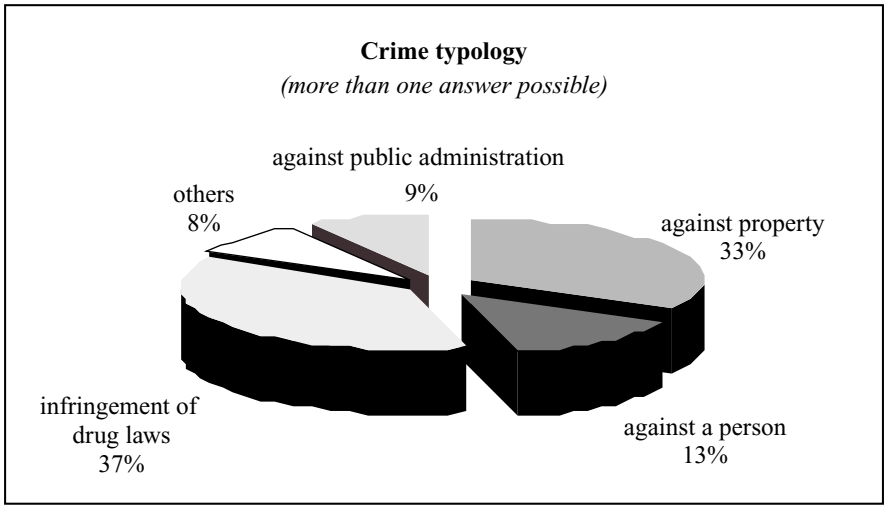
The figure changes slightly when asked about the past with 51% stating that they had penal precedents.

Legal problems in past (% of total answers given



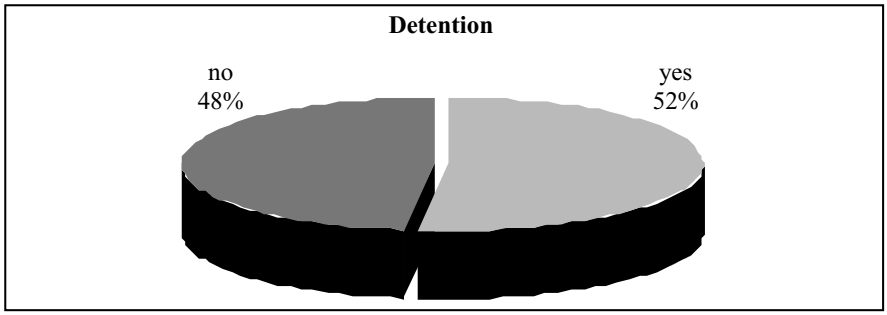
Both in reference to the past and to the last crime committed, the same distribution of the typology of crime can be observed, with a prevalence of offences concerning the violation of the law on drugs (37%) or offences of a patrimonial nature (33%).

Crime typology (% of total answers given

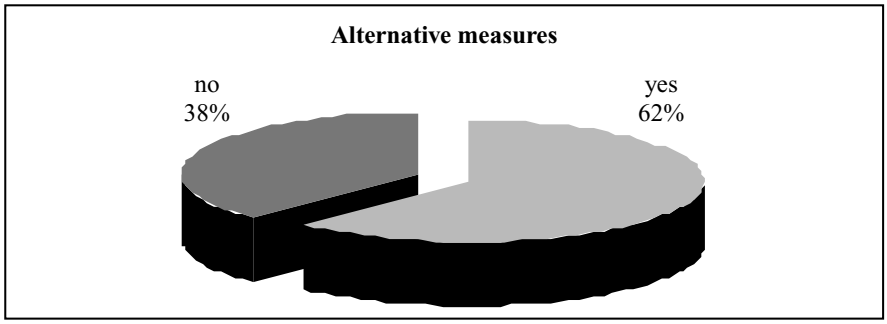


With reference to the past it can be observed how more than half of the women interviewed (52%) have been in prison, even if on average for short periods, and many underwent alternative measures to detention (62%).

Periods of detention (% of total of answers)

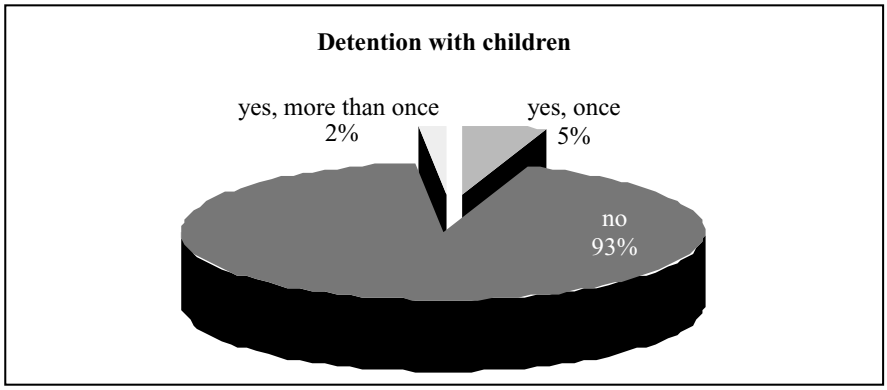


Alternative measures (% of total answers given)

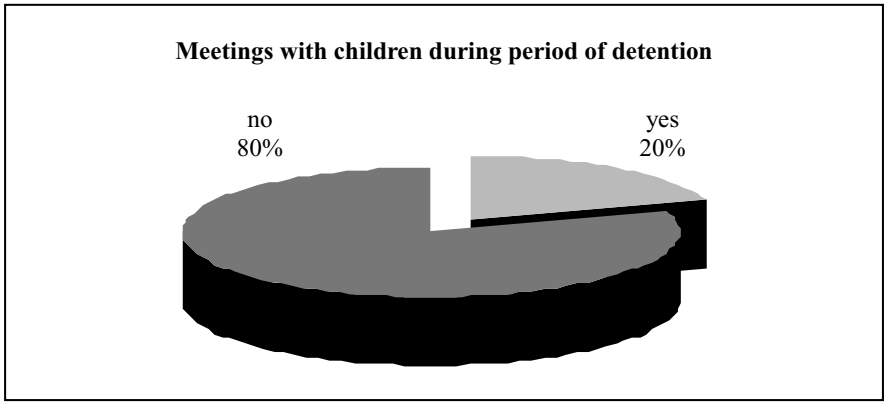


In 7% of the cases the drug addicts in prison with children (half of the European sample), declared that they kept their children in prison with them, even if only for very short periods of time, while 3.8% of them declared to have spoken to their children during the course of their imprisonment.

Detention with children (% of total answers given)

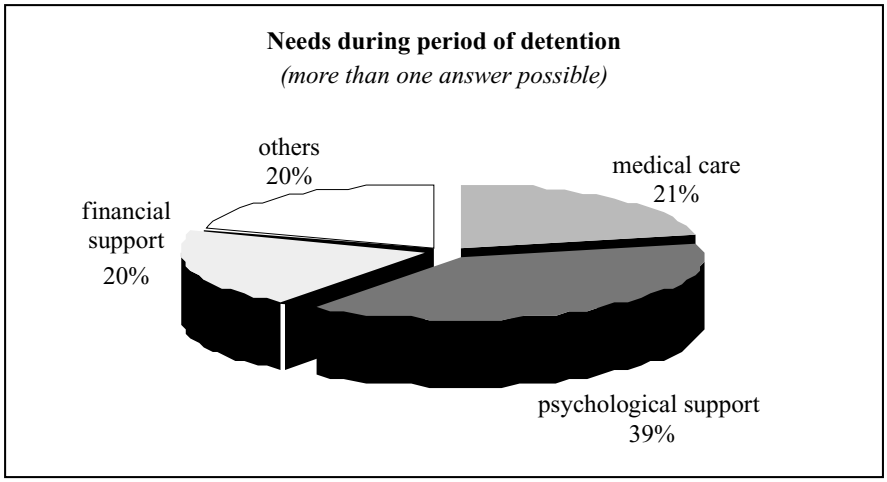


Meetings with children during period of detention (% of total answers given)



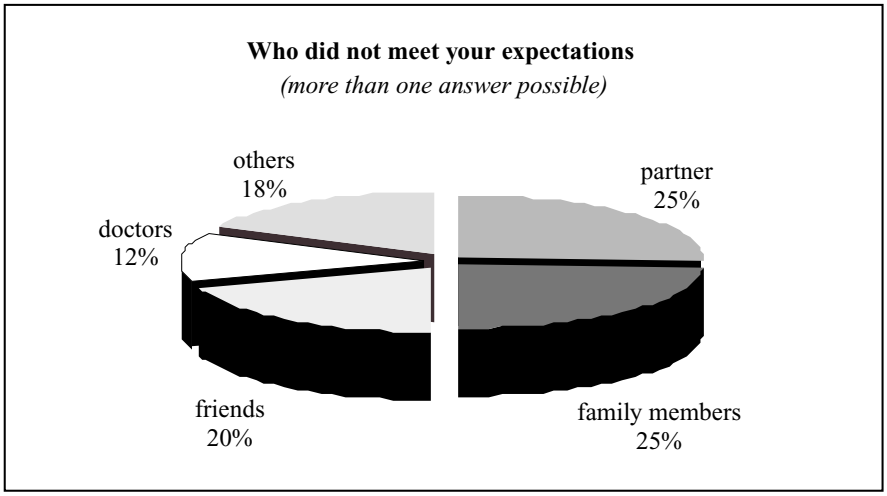
When the study on these women dealt with the experiences of discrimination and needs of female drug addicts in different contexts, it was noted that in connection to their period of detention their greatest needs were those usually felt by such women, that is first the need for psychological support (39%), and only then the need for medical treatment (21%) or financial support (20%); the greatest disappointments seemed to come from the behaviour of their partner and family.

Needs during detention (% of total answers given)

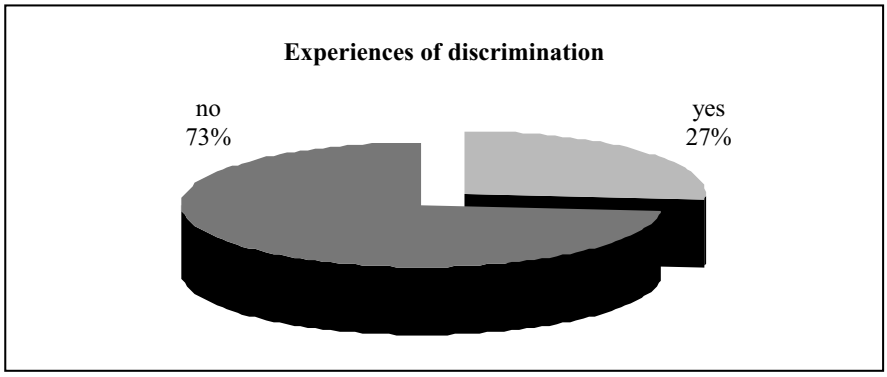


27% of the women who answered this item spoke of experiences of discrimination with respect to the other inmates.

Expectations not met (% of total of answers given)



Experienced discrimination (% of total answers given)



Even if the data from the above-mentioned sample does not seem quantitatively relevant for the stay of children in prison or the talks with the mothers in institutions, it nevertheless underlines how the problem should be considered in a much wider context, extended to all minors whose mother is an inmate, independent of the age limits foreseen by individual norms for their stay in prison with their mother.

In the light of this description, of interest is the declaration of the importance of offering equal opportunities of growth and development to such children by activating instruments, resources and concrete conditions with the aim of avoiding the damage that prison or separation involve ñ a declaration that was already made at a European level some years ago.

The problem involves the active role and responsibility of all institutional and extra-institutional services and their operators, with the aim of having adequate modes of

intervention for the social rehabilitation of female inmates with children that take into consideration their multiple needs and specific conditions. Accordingly, it would appear clear that particular interest must be paid to interventions aimed at women with problems of drug addiction, the maternity of whom would appear to present a double problem: on the one hand due to the difficulties caused by detention, and on the other due to all the factors linked to drug addiction, which, as has already been shown in the past by research by IREFREA, make the maternity of these women highly problematic (Stocco, Llopis Llacer, De Fazio, Calafat, Mendez 2000).

References

Bertrand M. A. (1998) *Prisons pour femmes.* Montréal, Edition du Méridien.

Biondi G. Daga L. (1989) *Madri e bambini in carcere.* Rassegna Penitenziaria e Criminologica.

Caddle D. (1998) *Age limits for babies in prison, some lessons from abroad.* Home Office Research, Development and Statistics Directorate, London, 80.

Campelli E. Faccioli F. Giordano V. Pitch T. (1992) *Donne in carcere: ricerca sulla detenzione femminile in Italia*.

Carrieri F. Catanesi R. (1999) *L'alcolista ed il tossicodipendente come autori e vittime di reato*. In Giusti G. (a cura di), Trattato di Medicina Legale e Scienze Affini, Cedam, Padova, Italy.

Conseil de l'Europe, Assemblée parlementaire, Mères et bébés en prison, Proposition de recommandation, Doc. 8479 1999.

Conseil de l'Europe, Assemblée parlementaire, Mères et bébés en prison, Rapport de la Commission des questiones sociales, de la santé et de la famille, Doc. 8762 2000.

Conseil de l'Europe, Mères et bébés en prisons, Recommmandation 1469 de l'Assemblée parlementaire-Projet de réponse 2000.

De Cataldo Neuburger L. (1996) *La criminalità femminile tra stereotipi culturali e malintese realtà.* Cedam, Padova, Italy.

De Fazio L. Luzzago A. *Tossicodipendenza e carcere: i riflessi di un cambiamento consumatorio.* Relazione presentata al XIV Congresso Nazionale della SIC, Gargnano del Garda, 2-4 marzo 2000, Atti in corso di stampa.

OEDT (1999) *Droga, i dati in Europa nel 1999.* Relazione, www.europalex.kataweb.it/Dossier.

Elaborazione Eurispes su dati del Dipartimento dell'Amministrazione Penitenziaria, http://www.eurispes.com.

Howard League for Penal Reforme (1993) *The voice of the child, the impact on children of their mother's imprisonment.* London.

Howard League for Penal Reform (1999) *In the best interests of babies?* London.

Luzzago A. Bolognesi W. De Fazio L. Donini W. Pietralunga S. *Percezione di ruolo materno e carcere.* in corso di stampa.

Malagoli Togliatti M. Mazzoni S. (1993) *Maternità e tossicodipendenza.* Giuffré, Milano, Italy.

Marinari M. Documento informativo dell'Ufficio Centrale Studi, Ricerche, legislazione ed Automazione sui dati relativi alla popolazione femminile detenuta, in De Cataldo Neuburger L. (a cura di) (1996) *La criminalità femminile tra stereotipi e malintese realtà.* Cedam, Padova, Italy.

Merzagora Betsos I. (2001) *Lezioni di Criminologia.* Cedam, Padova, Italy.

Ponti G. (1999) *Compendio di Criminologia.* Cortina, Milano, Italy.

Rosenbaum M. (1997) *Women: Research and Policy.* In J. H. Lowinson P. R. Ruiz R. B. Millman J. G. Langrod (eds) Substance Abuse, a Comprehensive Textbook, 3rd Baltimore, MD: Williams & Wilkins.

Stocco P. Llopis Llacer J. J. De Fazio L. Calafat A. Mendez F. (2000) *Women drug abuse in Europe: gender identity.* Martin Impresores, Valencia.

www.giustizia.it

6. ADDICTION AND GENDER CONDITIONING. EFFECTS OF THE PERSONALITY VARIABLES

By Juan José Llopis, Montse Rebollida

Introduction

The classical explanatory model of drug dependencies encompasses three already known factors: subject, drug and environment, and it is from their interaction that addiction will or will not develop, as will the seriousness and consequences of the same. If we are looking at the relationship between two of these factors, the drug and the subject, we must take into close consideration the importance of the personality traits of the man or woman who is using the addictive substances. At the same time, the environment in which the user moves, and the adaptation response to the demands and pressures of drug use will be mediated by the personality of the subject and this, in turn, will receive the imprint of the environmental influences of the milieu of the subject. Therefore, in view of this, the study of the personality traits of those people who present an addiction is of great interest when developing a theoretical model that assists in understanding the complex phenomenon of drug dependencies.

In this present text, we are carrying out an examination of the most notable theoretical aspects in relation to personality traits and drug addiction, and the methodological difficulties and practices for personality diagnosis in addicts, with special emphasis on antisocial traits, post-traumatic stress, depression and sensation-seeking behaviours. Subsequently, we analyse all these aspects, with specific application to the case of women drug addicts.

In the second section of the work, we set out the results of a comparative study of personality traits, measured with the Mini-Mult Test, on a sample of women addicted to opiates, and the traits of a second sample of male heroin addicts, and a control group comprising women with no addictive and/or psychiatric pathology. Finally, we present the data on the evolution of the personality traits of the two samples of addicts, with test-retest evaluation at commencement of treatment and at a two-year follow-up.

What we know about the preaddictive personality

The Antecedents.

We know that interest in investigating personality in addicts was already being shown thirty years ago (ASTIN 1959, GILBERT and LOMBARD 1967), but the analysis of personality in drug dependants is a controversial topic and one that has been in constant evolution since the first studies. Even so, there are many and varied

theoretical models that endeavour to explain the possible relationship between personality and drug use.

A large part of the research links drug use to personality to the extent that users of substance with a high addictive potential generally have more accentuated personality problems (HAMMERSLEY et al 1995).

Possible relationships have been noted between the genetic load and predisponent factors for drug abuse. TSUANG et al (1998), studied two groups of more than one thousand twins, both monozygotic and dizygotic, where they evaluated the possible relationship of genetic influence on drug use and found evidence to show that genetic influences contribute to vulnerability to drug use, and that each category of drugs, with the exception of the hallucinogens, presents unique genetic influences. In every case, the genetic influence of vulnerability to drug abuse was greater for heroin than for other drugs. Other studies carried out with samples of twins of both sexes highlight a greater genetic weight in men for vulnerability to drug abuse/dependency, with attributions that reach 60-80% of the genetic load in the development of drug abuse. (VAN Der BREE et al 98, KENDLER and PRESCOTT 98).

ROSE (98), in an examination of work on genetics and alcoholism risk behaviours in children, finds a significant correlation in genetically determined sensation-seeking behaviour and the subsequent problems of alcohol abuse. In this same publication, he reviews two Finnish studies carried out with twins which evaluate the possible risk factors and find both intergender and intragender differences in the risk of developing alcoholism so that the researchers of these twins attribute a significantly greater prevalence of high-risk behaviours to the girls in the high-risk groups, characterised by a poor adaptation to the group and greater aggressivity than the girls in the low-risk groups.

It is generally recognised that early initiation into drug use is the factor that is the best prognosticator of abuse in later stages. According to PONS and BERJANO (97), a determined personality type characterised by affective immaturity more than by emotional instability could be related to the initiation into use.

Almost two decades earlier KANDEL (1980) identifies three large groups of factors that influence the ingestion of drugs and classifies them in the order of importance that they have in this use:

- interpersonal: friends and parents;
- intrapersonal: which includes the previous personality;
- sociodemographics.

The way in which the personality characteristics and effects of addictive substances overlap in adolescents has certain special characteristics precisely as a result of the peculiarities of this evolutionary period and its subsequent implications.

CALAFAT and AMENGUAL (91) are of the opinion that the less organised the personality the greater the effects of drugs on it and certainly on its biological aspect.

The repercussion of drug use on the individual development of the subject is produced principally in the maturation and development stage of the adult roles, making

it difficult for the adolescent to achieve the necessary confrontation abilities to deal with life events and the preparation of individual mature responses, leading to an interruption or full stop in personal development at various levels: educational, social, employment and, of course, psychological.

NEWCOMB et al (86) point out that uncontrolled stress, the consequence of negative life events, creates a sensation of a loss of internal control which generates a low level of the significance of life, which is experienced as uncomfortable, and which would be self-medicated with the use of drugs. Emotional experiences in infancy may influence drug use to a great extent as is demonstrated by the substantial comorbidity between addiction and Post-Traumatic Stress Disorder (NESSE and BERRIDGE, 97).

Pursuing this same line of research, LABOUVIE (87) finds high frequencies in the intensity of use in respect of ego strength and control levels below the normal average in adolescents.

Other authors (NOGUERAS 93, WEISS et al 92) are also of the opinion that drug use in adolescents would be produced within a context of searching for alleviation from previous unpleasant situations, a self-medicating behaviour that appears as a result of personal problems or from difficulties in the social relationship, and which would be closely associated with depression in adolescence. In such cases, it generally happens that the effect of the drug is sought as a temporary substitute while achieving internal confrontation mechanisms. The big problem with these behaviours is that, with the passage of time, the use of drugs may remain as the only mechanism of confrontation or of alleviating the malaise impeding this individual maturation from occurring.

Drugs that induce positive emotions provoke a false signal of wellbeing that sets off the alarm and activates preference mechanisms which can lead to a continued use of drugs. A use of drugs where it is precisely because of its continuity that it no longer leads to pleasure. The drugs that block the negative emotions may deteriorate the self-defence strategies (self-efficiency) and reduce the capacity of the subject to confront stressful situations and unpleasant emotions, (NESSE and BERRIDGE , 97).

Moreover, the same authors are of the opinion that the drugs of abuse may also improve the mechanisms of adaptation to determined circumstances, encouraging the symptoms of a mental disorder or, on the contrary, inducing pleasure that may not be prejudicial (NESSE and BERRIDGE, 97).

The choice of substances will not be aleatory according to ARIAS (99), as previous experiences with different substances are determinant in choosing those that lead to alleviation of the dominant symptoms. Thus, symptoms of anxiety and depression improve with the use of alcohol, cannabis and opiates. The psychostimulants improve the depressive mood and increase energy. The opiates may alleviate the distrust that is, however, increased by cannabis. This in turn may be a good anxiolytic and activator, cocaine being taken precisely for this activator effect.

CHARNEY, NESTLER and BUNNEY (99) state that the common neurobiological bases between determined personality disorder traits and dual diagnosis with addictive disorders have been identified:

- behavioural disinhibition. Linked to antisocial and borderline personality disorders;
- CNS anxiety and excitability. Linked to avoidance and dependence disorders, schizoid disorder and borderline personality disorder;
- sensitivity to reinforcement. Linked to histrionic and narcissistic disorders.

The leading neurochemical hypotheses of these traits include dysfunctions in the serotonergic, dopaminergic, GABAergic, glutamatergic and opioid neurotransmissions. In this way, a relationship would be established that, according to the authors, would be as follows:

1. behavioural disinhibition: serotonergic and cortical dopaminergic hypofunction;
2. elevated anxiety: central GABAergic hypofunction;
3. neuronal excitability: cerebral glutamatergic hypofunction;
4. sensitivity to reinforcement: mesolimbic dopaminergic hypofunction and opioid hypofunction.

In the full flowering of psychobiology it has still not been possible to determine the variables influencing addictive behaviours up to the stage that what for many years was a theory - and possibly an overused one, such as the hypothesis of self-medication by deficits or endogenous dysfunctions in determined neurotransmission systems - is to be found undergoing a complete overhaul. At the same time, we should wait and see if the recent discoveries of the identification of the genome open up an enormous gateway to the understanding of a predisposition to suffer determined pathologies, such as addictive behaviour for example. The advances in research, over the years, into a possible predisposition to addiction according to personality bases have led to many endeavours to delimit a theoretical construct that would offer us an explanation as to why some people continue to use drugs to the point of addiction after their primary experiences whereas the majority, however, give up use after a period spent experimenting with drugs. The evidence, at the moment, is that it has not been possible to identify an explanatory model of the relationship between determined parameters such as personality traits and a possible predisposition to the development of an addiction to drugs.

Personality and addiction. Determinants

OUGHOURLIAN (77) emphasises that, in order to attempt to delimit the personality of the drug addict, the following has to be taken into account:

- previous personality profile: It is very difficult to establish previous personality criteria that subsequently correlate with the development of drug addiction;
- subsequent personality profile: the personality characteristics obtained in the studies are derived from research with drug addicted people so that they will be conditioned to a large extent by the pharmacological and social effects of use as well as the length of time such use continued.

On this line, the few longitudinal studies carried out on children and adolescents suggest that determined behavioural dimensions, such as anxiety, measured in infancy, predict the risk of addition (PULKKINEN and PITKANEN, 94).

According to a recent study published by VANYUKOV and TARTER (00) the association existing between drug use and antisocial behaviour may cause an early appearance of antisocial behaviour and this effect of precocity could be exacerbated by the correlation between phenotype and environment. Pursuing this line, studies made in various countries show that children with high levels of sensation-seeking behaviours and low levels in risk perception develop problems in respect of alcohol and other drugs with a greater frequency (ROSE 98).

The results of research into personality traits in Spanish addicts published by ORDOÑEZ FERNÁNDEZ et al. (93) leads them to conclude that there is no single factor that explains the behaviour of injecting drug addicts and that the length of the period of use seems to determine the evolution of the factors that configure the personality. Likewise, for DURAN (89) who states that it is risky to talk of a preaddictive personality since there does not appear to be any research with results that confirms it.

CALAFAT AND AMENGUAL (91) made a study on depression and drug addiction in which they put forward a sequence of life-events that shape the life of the addict and which, as the authors point out, would be the very ones that could assist in causing the appearance of depressive symptomatology:

Difficulties in Relationships with Parents
(particularly lack of identification with them)
↓
Depression
(and other traits)
↓
Greater necessity than others in the group during adolescence
↓
Greater susceptibility to peer group pressures
(than others who have a better relationship with their parents)
↓
Increase in the possibilities of being initiated into drug use
↓
Greater possibility of abuse due to depressivity
(and/or other personality characteristics)
↓
Presence of Depressive Symptoms
(due to the failure of the depressive personality combined with contact with drugs)

The influence of previous personality traits and, most particularly, the entire interrelationship with the social group would have a great deal of weight on drug use behaviour.

CABAL BRAVO et al (89), in an examination of the work on personality with addicts, establish the difference between those who sustain the existence of a heroin addict personality, with antisocial or psychopathic deviance as the prevalent trait, and those authors that consider it in terms of profiles, in other words as a combination of different traits that can define a personality constellation. The authors conclude "... few authors who sustain the existence of a unique heroin addict personality, it not being possible after multiple studies to confirm that the traits that configure the personality of heroin addicts constitute an authentic heroin addict personality".

It has only been possible to identify the traits that could be present, to a greater or lesser extent, in the addict population. The addicts studied frequently present antisocial personality traits showing characteristics of Antisocial Personality Disorder (APD) such as emotional and affective instability and the marginality that would act as precursors to addiction (LAQUEILLE 98).

According to many authors, the personality variables that predict an abusive consumption of alcohol and drugs are the same as those related to antisocial behaviour. The majority of the works examined show a tendency to point out a number of traits that would incorporated in the concept of Antisocial Disorder such as lack of interest, lack of empathy, lack of self-control, socialisation problems and the search for instant gratification. At the same time, in spite of not being able to delimit a characteristic personality that explains the genesis of the addictions according to present diagnostic systems, recent clinical and epidemiological studies consider that the sensation-seeking trait may be an important psychological correlate in the generation of drug use.

What is most probable is that antisocial behaviour may constitute a common basis of many addictions as well as other non-adaptive behaviours but the relationship between Antisocial Disorder and addictive personality is only likely to be of any value in a small group of addicts with antisocial behaviours during infancy, prior to initiation into addiction.

Most of the studies on opiate addicts carried out in an endeavour to define the existence of an addictive personality have not been able to verify the existence of the so-called preaddictive personality.

In any case, we should ask ourselves if determined personality traits highlighted in the studies can be taken into account as precursors to drug abuse/dependency such as antisocial behaviour, the sensation-seeking trait, depressivity or the consequences of posttraumatic stress. If so, addiction would have to be understood as the manifestation of an underlying characterological disorder that would lead the subject to search for an immediate satisfaction in which the possible adverse consequences in the medium and long term of his or her behaviour would not be taken into consideration.

Diagnostic difficulties

The evaluation and diagnosis of personality in addicts is not easy. It presents a number of problematics derived from the theoretical conception of the researcher, from the method utilised, from the centre where the research was carried out, and from the duration of the follow-up (RASKIN and MILLER, 93).

The DSM criteria refer to aspects of functioning and social behaviours understanding that alterations to behaviour are the consequence of these pre-existing disorders and/or psychopathologies. Specifically, the Behaviour Disorders and the Antisocial Personality Disorders are closely related to substance abuse (DARKE et al 94, PARKER and WILHEIM 95) although we are possibly finding ourselves faced with a risk inherent in the diagnostic method itself in that one of the symptoms that is generally utilised in the diagnosis of Antisocial Personality Disorder is addiction to psychoactive substances itself (BUCKSTEIN et al 89).

BROONER et al (92) point out that many drug dependants cannot be diagnosed with Antisocial Personality according to DSM criteria because such antisocial behaviours have not been produced until adulthood, as a consequence of their addiction, and not prior to 15 years of age. In spite of this, the authors indicate that the group of drug dependants with previous antisocial behaviours should be taken closely into account as these behaviours intensify and affect more areas of social functioning in adulthood. Other authors point out the importance of APD diagnosis as an aggravating factor in the evolution of the addiction on being associated with a greater tendency to share syringes (LESHNER 99).

The same diagnostic manual, the DSM IV, clearly shows that in those cases in which an APD is associated in an adult with an addiction, an APD diagnosis should not be made unless both have appeared in infancy and both continue to be present in the adult age. In this case, according to the DSM IV, both will be diagnosed assuming that both comply with the criteria of the two disorders, even although part of the antisocial behaviours may be a consequence of the addiction. And, with this, we have now returned to where we began without having succeeded in clarifying the diagnostic doubt about what is cause and what is consequence.

The degree of agreement between diagnostic interviews and questionnaires for diagnosing personality disorders in addicts is very slight, with obvious disparities between the ICD and DSM criteria, to the extent that some studies of drug-addicted population diagnosed a prevalence of 7% ADP with restrictive RDC criteria, 29% if the asocial behaviours resulting from drug use are included, and up to 53% when the criteria applied to the same population were those of the DSM (HASIN and GRANT 87).

The personality disorder most closely linked to addiction is the ADP, and to such an extent that very often, addicts are erroneously considered to be psychopaths on the basis of their frequent antisocial and delinquent behaviours, similar psychodiagnostic criteria

and the social rejection that they suffer. Frequently, the high and, at the same time, disparate figures of ADP prevalence in addicts are a result of the problems of the evaluation instruments, methodological differences and to the presence of delinquent behaviours once addiction is established, as it is very difficult to differentiate the nuclear psychopathic traits from the antisocial behaviours that are the consequence of use. There is also the influence of certain particularly conflictive samples that overevaluate the results. If these factors are controlled, the prevalence of ADP in addicts falls significantly although it continues to be very important as it does exceed 10% (ARIAS 99).

The addict has been characterised by such traits as impulsivity, the search for emotional and exciting experiences, difficulty in maintaining stable social relationships, socially nonadaptive activities... As we can see, many of the variables that are related to or which predict drug use are associated with not only antisocial behaviour but also the sensation-seeking trait, which can be a psychological correlation of great importance in understanding addictive behaviour. The possibility of a neurobiological reinforcement role in the sensation-seeking behaviour has even been suggested which would imply a biological predisposition to experience greater sensitivity to the reinforcement, particularly to reinforcements associated with risk, novelty or hyperstimulation situations (ZUCKERMAN 83).

As for the sensation-seeking trait, many studies have been made during the last few years that endeavour to relate this trait to the development of addiction. Recently, SAIZ et al (01) published a study on the use of MDMA and the rate of multi-drug use among students in a region of Spain, in which drug users scored significantly higher on the sensation-seeking scale and, most particularly, on the disinhibition subscale.

SARRAMON et al (99) evaluate three dimensions of personality in drug user and non-user psychiatric patients in order to establish whether these traits were common to the addictive subjects, through a transversal study. In their results they find a significant relationship between the sensation-seeking trait and the increase in the possibility of developing addiction. In the same work, they point out that the other two traits that multiplied the risk of developing addiction were the impulsivity and anhedonia scales.

We can see that the depression or depressivity traits are also significantly related to the abuse of addictive substances. BUCKSTEIN et al (89) indicate a high incidence of depressive symptoms in adults with substance abuse, but in adolescents the symptomatology observed does not support the diagnosis of depression. Other authors are more inclined towards the depressivity concept being applied to adolescents. (CALAFAT and AMENGUAL, 91). CASANOVAS et al (96), in a study of Spanish university students, finds that 66.5% have used addictive substances, employing them as self-medication, it being observed that 3.8% of them showed obvious depressive traits or were using drugs to improve their mood.

SOLER and GRAU (88) state that depression at commencement of treatment in an addict is related to a poor psychological state and a greater use of drugs and that it evolves positively without specific antidepressive treatment, and can be related to

alterations of the endorphinic and neurotransmission systems as a result of a lack of stimulus of the opiate receptor produced by stopping use or on the initiation of treatment, a point in time where the addict can present symptoms related to the acute period of the abstinence syndrome or related to a psychosocial crisis. Practically at the same time, DeMILIO (89) perfects these concepts further on finding in a sample of hospitalised adolescent addicts and with other psychiatric disorders, that 18% presented depression criteria on admittance which disappeared after 15 days abstinence. Similar results are observed by STRAIN et al (91) in a follow-up of depressive symptoms in opiate addicts undergoing treatment with methadone, where they find a significant reduction in the Beck Inventory scores after the first seven days, and which the authors attribute to the fall in the use of heroin.

Another diagnostic problem is provoked by the fact that many clinicians and researchers tend to establish a diagnosis of depression in a static way, without taking into account the combination of symptoms, the duration of the same and the degree of affection that results (FACY et al 87). Nor do they evaluate a tendency to present affective and anxiety disorders or greater depression, something which certain authors state that addicts develop throughout their life (KELL 95).

The peculiarities of the demand for treatment, the time at which the interview generally takes place and the different motivations for treatment, not always the most sincere, have a crucial influence on the personality diagnosis. We agree with ROUSANVILLE (89) that as a result of the evaluation instrument being used and the clinical criteria, significant variations may appear in the diagnosis, emphasising determined personality disorders.

During our research, we were able to find traits that presented a posteriori, in other words when the drug addiction had continued for several years, and we found that the appearance of low self-esteem, feelings of insecurity, low tolerance to frustration, impulsivity, emotional hardness, rebellion against those in authority, need for immediate gratification, scepticism, lack of interest and irritability were common. It is difficult to conclude from such traits whether or not they have been provoked by the years of addiction behaviour or if they existed previously. What is important, is to take into account all these traits in the evaluation of the addict in that they favour low expectations from life, low levels of self-esteem, insecurity, and a low tolerance of frustration. Attitudes that are going to be determinant in the evolution of the addiction and its treatment (TORRES 99).

From the review we made of publications, there is a notable recent work by two Russian authors (KOZLOV and ROKHLINA 00) in which they study a wide range of addicts and arrive at a definition of the components of what they call the “addictive personality” and which would be characterised by high excitability, progressive affective disorders with dysphoria and depression, affective ability, the presence of forms of response of a hysterical type, psychosocial dysfunction with gradual loss of interest, different anomalies in the emotional sphere and impulse control disorder including impulses of a sexual nature. What we are seeing here is the constellation of

traits that describes practically all addicts after several years of use and which we have already covered in preceding paragraphs. The work presents certain methodological lacunae in the selection of the sample and this could influence the diversity of personality traits encountered.

In addition, affective immaturity, intolerance to frustration, inability to handle and internalise feelings, inability to accept delay, irresponsibility, affective dependency and deficits in the evaluation of the consequences of their actions have also been described as characteristics of addicts.

Within the difficulties inherent in the diagnostic method, if we focus on the diagnoses by axes, we find an evident problematic when making multiple or inter-axis diagnoses and it is this that constitutes its poor stability in that it is necessary to follow the evolution of the case to be able to differentiate the symptomatology of the addiction from that of other pathologies. This type of diagnosis implies a distinction between primary and secondary, and this refers to the chronological sequence of appearance. The criteria of principal and secondary diagnoses refer to a greater severity of one or other at the time. Both criteria present poor reliability in the evaluation methods in that they are describing the chronological order more than the etiological one and, therefore, there is no attempt to determine if one pathological process is a reaction to another.

A good summary of all these topics continues to be the one by BERJANO and MUSITU (87) made after a review of the aspects of personality of addicts taken from different studies and which gives the following as the most frequent traits:

- need for instant gratification;
- intolerance of frustration;
- infantile tendency to anxiety that provokes pseudoadaptive mechanisms of a regressive type;
- motivation centred on self and interests directed at own intimacy;
- emotional instability;
- rebellion, basically self-assertion, directed at figures of authority;
- living almost exclusively at pathic levels of psychological functioning with polarities of the pleasure-displeasure, liking-disliking type;
- reduction in ability to assume responsibilities, plan and accept a wait.
- total loss of interest when the external reality is not immensely and immediately gratifying.

As we mentioned earlier, some of the diagnostic difficulties in defining personality in addicts are derived from the instrument being utilised. The diversity of the questionnaires employed in the different surveys means that the results of one are not always comparable with the results of another, to such an extent that on reviewing the literature, we find ourselves with a further obstacle when endeavouring to establish definitive personality traits in drug addicts.

Personality diagnostic instruments. Profile versus addictive traits.

As for diagnoses with questionnaires on personality, the impression is that the MMPI has been an obligatory reference. The first articles studying the MMPI profiles of addicts to opiates were published in 1959 by HAERTZEN and HILL and by ASTIN (59), making it possible to discriminate between the addict and non-addict population. At the same time, it differentiated four subtypes of profiles in addicts: Primary Psychopaths, Schizoid Psychopaths, Neurotic Psychopaths and Non- classifiable on the basis of the elevations on the MMPI Pd scales. For the last group, the "non-classifiable", Astin analysed the items on the Pd scale, which then enabled him to distinguish between depressives and non-depressives associated with the addiction itself. In order to understand these distinctions, it is necessary to make a temporal abstraction by placing ourselves in an earlier era prior to the establishment of a consensus on international criteria and to underline the importance of this first approach to the establishment of differential personality traits between addict subpopulations.

In 1982, Craig described a MMPI scale to identify heroin addicts that he called the "He" Scale. Two years later, CRAIG (84) carried out certain studies, as a result of which he rejected the "He" Scale as being discriminatory in populations addicted to various substances, pointing out that the diversity of profiles of the MMPI between among addicts is apparent only, and that none of these profiles may be considered as prototypical of the drug addict.

The predominance of sociopathic characteristics, however, among the descriptors of personality in male heroin addicts is not surprising, and has been well documented in the literature (ASTIN 59, WEISSMAN 70, STUCKER, 79). The majority of the studies made with the MMPI describe two types of profiles, one, subjects with elevations on the D and Pd Scales and secondary elevations on the Sc Scale and another with a profile characterised by primary elevation on the Pd scale (CABAL BRAVO et al 89).

This constant in the studies means that it leads to classification of the systematic elevation of the Pd scale above the percentiles within the range of normality as the principal characteristic of the addict personality which, as was pointed out by FACY et al (87), could be an abusive labelling of psychopathy in drug addicts and which, in reality, reflects the lack of the necessary in-depth assessment to integrate and understand the phenomenon of drug dependency within its coordinates, revealing a static view that does not take into consideration the evolution of the process (ALTERMAN and CACCIOLA 91).

In a study by STUCKER and MOAN (72), with the MMPI descriptions of three groups of socially deviant women and of heroin addicts in prison, these latter responded in a significantly more deviant way on the antisocial inclination indices (F, Pd and Ma scales) than the prisoners with no history of addiction. In a sample of men, however, on comparing addict subjects at large with addict and non-addict prisoners, the subjects at large sample scored higher on the scales that form the Neurotic Triad (Hs, D and Hy) and on the Pd. This would perhaps suggest that the significant elevations were, in part,

situational, reflecting the response to transitory pressures, environmental factors, physiological effects and to the psychological demand of an addiction habitually supported by illegal means.

The reactive nature of the elevation on some scales has been suggested by several authors (FERNÁNDEZ, 96). In fact, some personality traits in addicts, such as the depressive or psychopathic traits, must have originated in the addiction itself more than in the premorbid personality. WOOLF-REEVE (90) is of the opinion that heroin addicts undergoing treatment have symptoms of serious mental illness, and suggests that there should be a continual evaluation of the patients and their symptomatology in order to treat them adequately.

HURT et al (90), on the other hand, using the MMPI, measure personality disorders in 67 drug addict patients, repeating the evaluation after a brief period of admission for substance abuse without finding particularly significant traits but finding high levels of stability in the traits, without great modifications after abstinence.

WALFISH and cols (90), employing the MMPI on 243 young drug dependants undergoing hospital treatment, found a significant elevation of the psychopathic deviate trait (Pd), when comparing them with other studies that encountered the same findings.

STUCKER et al (74), employing the MMPI, examines personality traits through test-retest procedures for two similar groups of heroin addicts, both of which were hospitalised. The changes in the MMPI were characterised by very high scores on the strength of ego scales and on personal care, and on Pd and Ma, with a subsequent fall on almost all the clinical scales, the Hs and Hy scores being particularly sensitive to circumstantial changes.

LAVELLE and cols (91) administered the MMPI to 210 young people distributed between non-users, users who did not inject and injecting drug users and, on the basis of the results, drew up a scale of 37 items that distinguished between drug users and non-users. The assessment was made with 214 subjects included in drug or alcoholism treatment programmes as well as the adequate control groups. The Drug Abuse Scale was useful in distinguishing between both groups. The McANDREW Scale, on the other hand, was shown to be more useful in distinguishing those among them who were abusing drugs.

As we can see, the MMPI is practically a constant in research into personality traits in addicts but as a result of its length, in the main, which makes it difficult for many addicts to complete it, shorter forms are being developed and broken down from it, particularly the Mini-Mult which is notable for its great simplicity, validity and reliability (KINCANNON 68, GAINES and ABRAMS 74, EDINGER et al 76). In addition, the Mini-Mult questionnaire is the one that we have been using to assess addict patients in contact with our services for drug dependants and in the different published studies (LLOPIS et al 92, TORRES et al 95, LLOPIS 97).

DUTHIE and BORRERO-HERNÁNDEZ (79) used the Mini-Mult to differentiate heroin addict outpatients from psychiatric outpatients and normal population. They

carried out a multiple discriminant analysis on 30 subjects who were compared by means of the 11 Mini-Mult scales. The results were significant in the following scales: L, F, Hs, D, Hy and Pd.

SKUJA and cols (80), employing the Mini-Mult and the Comrey Personality Scale on a group of 45 alcoholics undergoing treatment, determined that there were several elevated scales such as Pd, Pa and Sc, the last two falling significantly after treatment and training in how to live without alcohol which the authors interpret as the result of perceiving fewer feelings of isolation at the same time as impulsivity was also being reduced.

In Spain, FACY et al (87) studying personality characteristics in addicts under 20 years of age, find significant elevations on various scales, principally D and Pd. The majority of the studies carried out in Spain using the Mini-Mult were employed on the alcoholic population, thus, MONRAS and SALAMERO (87) find high scores in alcoholic patients on the D, Sc, Hs and Pt scales. The majority of these studies coincide in pointing out pathological profiles, particularly as a consequence of the elevation on the depression scale.

In 1992, using the Mini-Mult to compare a population of women heroin addicts with alcoholic women and a control group of healthy women, we were able to find results with similar profiles in both groups of women addicts with elevations on the D, Pd and Sc scales, and significantly different from the control group, LLOPIS et al (92).

TORRES et al (95) study the addict population through the Mini-Mult test-retest, observing high percentages on the D, Pd and Sc scales in the first test with lowered scores on the second test.

With the use of the MMPI, it has been possible to determine a number of triads in addicts, among which the neurotic triad predominates, with high scores on the Hs, De, and Hy scales associated with a low self-esteem and a predominance of anxiety that leads it to be said that the personality could exercise a causal influence on both drug use and on the state of health and affective state (TORRES, 99).

These results have a relative validity in that they are studies carried out with subjects, very often with a long history as addicts without it being able to conclude by demonstrating that these traits were prior to the addiction or that they are modifications that the addictive behaviour makes to personality traits.

As for the use of other personality questionnaires, this has been very varied so that we will only be reviewing some examples of the most outstanding of these. Briefly, we have CRAIG et al. (89) who study two samples of drug dependants through the Adjective Checklist (ADC) and state that patients treated as outpatients have less psychopathological traits than those treated through admission to hospital.

CALSYN and SAXON (90) state that drug addicts suffer psychiatric disorders with a higher frequency and number than non-users, these disorders being difficult to distinguish and classify in clinical practice. They employ the Millon Clinical Multiaxial Inventory (MCMI) in order to determine DSM-III-R Axis I in 73 heroin addict patients,

and they identify: subjects with psychotic disorders, subjects with affective disorders and subjects with personality disorders. NADEAU et al (99) also use the Millon to evaluate 225 Canadian addict patients undergoing treatment, of which 88% presented personality disorders. The scale with the highest score was the passive-aggressive disorder followed by the dependent and borderline personality disorders. The presence of pathological scores in APD was the lowest.

STEER et al (89) study Dutch and American heroin addicts employing the SCL-90, and they find three components or traits correctly classified in the following order; anxiety-depression traits, hostility and paranoid syndromes. In addition, they observe that the use of marihuana was coupled with paranoia, but they did not encounter any specific traits for the heroin addicts.

Utilising the same SCL-90, MARTÍNEZ HIGUERAS (93) also finds maximum scores in the sample of drug dependants on the depression scale, followed by compulsion-obsession and somatization. The same results of high scores on the depression scale was obtained by BOLINCHES et al (96) together with general elevation of all the SCL-90 scales in drug dependants. The authors point out that at a 6-month follow-up a significant descent was produced in the scores in all areas.

CABAL-BRAVO et al (90) employ Murray's TAT for a comparison of psychopathological traits between a group of heroin addicts undergoing treatment with methadone and a control group, without detecting a uniform structure of personality in heroin addicts but they do find clear differences in comparison with the non-addicts (low esteem, suicidal tendency, elevated anxiety, etc.).

SWIFT et al (90), employing the GHQ-28 as a nondiagnostic measurement of minor psychopathology, demonstrated that 61 % of heroin addicts under treatment in a centre on the outskirts of a British city presented psychological and social dysfunctions.

ORDOÑEZ et al (93) utilise the WAISS and EPQ-A questionnaires by Eyseneck to study a sample of injecting drug addicts but did not find any single personality factor explaining injecting addict behaviour.

ETXEGOIEN et al (96) utilise Cattell's 16 PF to study a sample of patients in maintenance treatment with methadone, and they observes high scores in anxiety and lack of confidence and low scores in integration, socialisation and super-ego strength. SÁNCHEZ-HERVÁS and BERJANO (96) used the same questionnaire to compare the personality characteristics of a group of Spanish addicts with a non-user group and did not find significant differences between both groups, although they do point out that the addicts studied are more emotionally unstable and tend to have a higher frequency in evading responsibilities, and this would fall within the characteristics that define antisocial behaviour.

The C.A.Q. has been employed to simultaneously measure normal traits and psychopathological personality traits. BELAUSTEGUI (00) utilises it to assess addict patients undergoing semi-residential or day centre treatment compared with a non-addict control group, and finds a higher incidence of pathological traits in the addicts

group, most notably the indicators of depression, paranoia and psychoticism. Curiously, they did not find differences on the psychopathic deviate scales between the two groups.

The most notable feature in the different works, irrespective of the evaluation instrument employed in the study of personality traits in the addict population, is once again the difficulty in establishing a definitive profile. However, determined traits are being repeated, although, with all the methodological difficulties pointed out, the majority of the publications highlight the antisocial or sociopathic traits, the depressives traits and the sensation-seeking trait. In the following section, we will focus on all these subjects in the study of the traits of women addicted to opiates in particular.

Personality and Addiction in Women

Could we speak of a female predisposition?

The data on drug use raises differences between genders. According to the results of the national NHSDA survey carried out in the EU, 8.1% of the men and 4.5% of women over 12 years of age have taken illegal drugs. These gender differences in drug use are not, however, related to differences in susceptibility. In fact, although prevalence in drug use is higher among males, it would appear that the opportunities for initiation are the same for both sexes (ZICKLER 00).

Both the opportunities and the offers that initiate use and the percentage of users present a distribution by sexes (2:1) very different to that offered by health resources in the demands for treatment (4:1, or 6:1), leading to the raising of certain obligatory questions. What is the reason for this low presence of women in the health resources for drug dependants? Is there any determinant factor in the development of addiction that marks differences between genders?

A recent study by the John Hopkins University (VAN ETTEN and ANTHONY 99) shows this difference between the opportunity to initiate use and the probability of continuing use, according to gender. Although women had higher probabilities than men of acceding to drug use, they did not encounter significant differences in respect of continuing use nor in the age of initiation to heroin. According to this work, once the first opportunity of taking heroin is presented, an event that occurs in 7.8% of the men and 3.2 % of the women, 22% of these women will use it again within the period of one year but only 14% of the men within the year following their first opportunity. As we see, the difference is important and must make us think of some factor, internal or external, that is influencing this transition.

It would appear that the strategies utilised to resist the direct pressures of drugs obtain different results according to the sex of the person receiving them. As MOON et al (99) point out, women have less success in rejecting pressures to use drugs, above all if these are reiterated, and this indicates a higher susceptibility. This circumstance is fundamental in being able to design a prevention programme that obtains better results

than the current ones for women and, in addition, it reaffirms the idea that the personality factor is key at the time of marking the differences between genders and their relationship with drugs.

Reading the texts and the analysis of the research, leads us, in one form or another, to what would appear to be evident. At this time, the possible psychological difference between the sexes is a question that has still not been answered. To what point is it inherent in the genetic sex? Should we evaluate or, on the contrary, ignore the result of cultural and educational influence? Is the environment determinant for women?

From our point of view, these unknowns must be examined on the basis of an objective analysis of the factors that integrate them.

It is undeniable that the process of equality and liberalisation has led to an improvement in many psychosocial aspects of women but we must also take into account that the result has often been quite the contrary with a maladjustment between social demands towards independence and achievement of position on the social scale as opposed to the cultural values transmitted by an androcentric education that ends by being internalised in women.

Traditionally, the woman has been assigned a social and cultural role that has determined a personality structure and a way of relating to others crucial to her socialisation process.

Changes have been produced over the last few decades, particularly in the diversification of the traditional role of the woman in our society as a consequence of her incorporation in the labour world and the opening towards the world of social relationships introducing a transcendental change in the traditional way of considering the relationship of women with alcohol and other drugs.

The adolescent stage is particularly crucial for the woman given that the social and biological forces that are going to encourage her to assume her own identity are different from those exercised over men who receive less pressures as a reflection of the roles traditionally assigned to each gender in all societies.

At the same time, the classical feminine cycles have also undergone a number of modifications: the biological cycle, the conjugal family cycle and the professional-vocational-educational cycle) have evolved, enriching, but at the same time complicating, the life of women.

NAVARRO et al (00), in a recent study on abusive substance use in women in the general Spanish population, structure the risk factors in drug use into four groups, pointing out those variables with a greater relationship of probability in each one, and which, according to the author, are predictors of use in 78% of the cases in the female collective, and in 81.6% of schoolchildren.

- Family Factors.- In which the variables with greater weight would be parental antecedents of alcohol or drug abuse together with the stress produced by having

to deal with the domestic tasks after a working day outside the home. The poor relationship with her partner is also notable.

- Personal Factors.- The greater probability of presenting a sensation of oppression and constant tension and negative feelings derived from not being able to overcome the difficulties and problems and, finally, personal dissatisfaction.
- Social Factor.- On the one hand, the use of drugs within the group in the recreational environment in contact with every kind of addictive substance. On the other, the lack of social participation and lack of solidarity.
- Labour factors.- Employment frustration arising from dissatisfaction and lack of security in terms of the future, stressful and exhausting working days followed by household tasks.

Many of the variables that integrate these factors share properties to the extent that their influence may well affect several groups or set up a chain reaction -a domino effect, in other words- so that the point comes when there is no clear delimitation between personal, social, labour factors.

The increasingly higher level of studies and professionalism of women confirm their ascent on the social significance scale which, in theory, should tend to situate them in a position of equality with men, however, what is actually being achieved is complicating the social role of woman even more. On the one hand, she continues to be mother/wife at the same time as she is developing her new role as a salaried employee or professional in a kind of hypertrophy of the role of housewife.

Her improved incorporation in the labour market at the different levels is a fact. But the question that should be asked is if such incorporation translates into a greater degree of emancipation and wellbeing, which would be desirable, as the existence of inequalities at all levels is undeniable. In addition, it has to be taken into account that the social changes have not eradicated the classical division of gender functions. The woman is traditionally assigned the care of the house and the children -probably on the basis of a reproductive function- to which must now be added her new role as an efficient and competitive worker outside the home. But the reality is that her most valued role continues to be that as a housewife and the professional work is relegated to a secondary plane so that there is no possibility of her entering into direct competition with the male (GOMEZ 00).

The result is an evident duality for the woman. Emancipation on the one hand, and the conflict with authority, the man, her partner, on the other, which will have negative repercussions on the family environment. The possible responses to this situation will come from the woman herself through a clear definition of her new role and by setting limits, and also from society when it begins to value the woman both as a person and as a woman who works.

In western society, the role of the family is clear. It is a transmitter of values and elements of individual socialisation. The functions of the family as a social institution have also been changing over time and its importance in the meshing of the social

networks of each individual has also decreased, although certain functions continue to be inherent to the family and not to other social groups, in such a way that each family can establish a model of adaptive functioning according to the context in which it is enframed (GOMEZ 00).

In addition, the family must be regarded as a dynamic structure within an evolutive process in which, as its members go on developing, it takes on specific functional traits and necessities. At the present time, and in spite of the evolution of the roles already mentioned, the mother continues to be the most important element in the process of the maturation of children It is from the nature and intensity of the maternal/filial relationship that many of the ways of reacting to future conflicts will arise, and the expression of feelings or any other emotional tension could be seen as a danger, which will go on creating a series of mechanisms to control and, in particular, attempt to neutralise all that could endanger the family equilibrium. This situation ends up consolidating a submissive and subsidiary role to the dominant family role and, at the same time, the woman learns to silence her internal cry of anguish and to support disagreeable states, very often with the aid of the effects of depressive drugs.

In differentiating between the factors of higher probability, NAVARRO (00) finds in the research mentioned above that the group of risk factors with the greatest statistical probability for schoolgirls is that of the social factors but for the general female population the family and personal/psychological environment are determinants.

In adolescents, the influence of the group and the presence and accessibility to drugs through those they know, their partner in particular, would be determinants and even more so if we take into account that all this is generally linked to a form of managing leisure intimately related to drug use. Among schoolgirls, poor parent-children relations and the excessively frequent paternal/maternal abuse of alcohol are very important risk factors that have a significant presence combined with obsessive situations, family tension, indifference, and lack of communication. Another factor to which we must give increasing importance is the large number of antecedents of sexual abuse in infancy that is to be found in the studies on female addicts (LLOPIS 97), a sexual abuse that is very often produced within the family itself.

All these variables fall within the most intimate and personal sphere, being interiorised at a tremendously important time, as this is when the structure of personality is taking shape. The result is feelings of obsession and tension, dissatisfaction, lack of self-efficiency with a feeling of not being able to overcome the difficulties, a search for compensation for the discomfort, and evasion of frustration behaviours (NAVARRO 00).

The influence of all these variables and their evolution on the characteristics of socialisation and, following on from that, the relationships and behaviours of the woman has undergone profound changes.

As SEIDEN (89) pointed out, throughout her biological development, a woman experiences a number of events that will influence her personality characteristics in a very particular way:

- in her school years, behaviour problems emerge but depression may not yet make itself known; at the same time, the attention deficit disorder is more difficult to diagnose in girls as the hyperkinesia is not so obvious;
- in the early years of adolescence, the girl has to face bodily changes, may be the object of sexual abuses and her search for independence may lead her, during this stage, to use drugs and/or alcohol, unwanted pregnancies or a tendency to escape;
- at the end of adolescence, and in the first few years of adulthood, food disorders may appear in addition to psychosis or affective problems that bring with them the risk of suicide together with another characteristic risk of this stage – impulsivity.

Determinants in the personality of the woman addict

In 1988 BLOCK et al. carried out a prospective study of infancy to adolescence on a sample of general population and found that the results show that the personality characteristics observed in infancy are very closely linked to the characteristics observed in adolescence and also with the use of psychoactive substances at this stage in life. Moreover, they observed a higher frequency of drug use by the girls.

The household survey (NHSDA) on the use of drugs in the EU in 1966 indicates that among the most probable health risks in women addicts depression and low self-esteem are most notable (NIDA 01).

According to other authors, many of these personality characteristics would be artificial and not inherent to the gender as such. PARKER and WILHELM (95) point out that in general population studies where the possible social determinants are not controlled, the female preponderance of depression in adults is notable. However, if social factors are controlled this preponderance decreases.

In studies on cocaine and alcohol addicts sponsored by the NIDA (BRADY et al. 93. SWAN 97), they find that men have more probabilities of being diagnosed for depression than women, no doubt in obedience to the effects of the addiction. On the other hand, these same authors suggest that depression appears in women with a greater frequency prior to drug use.

Many women drug dependants have had some experience of physical/sexual abuse in the home at early ages (BLUME, 94, LLOPIS 97), so that substance abuse and the associated behaviours become normal reactions to abnormal situations. Normal emotions, however, are medicated and ignored. Natural and normal reactions are rarely exteriorised in the chaotic family situations in which the woman addict developed (HAGAN et al 94).

Dr. Brady (BRADY et al 93) states that the results of her study imply that the divers psychiatric factors may have different roles as predictors of drug abuse in comparison

with men. In the women in her study, the Post-traumatic Stress Disorder preceded dependency on cocaine in 77% of the cases and they affirm that it would seem to be closely related with antecedents of sexual and physical abuse, which is fundamental to the important differences between genders. For BLUME (94), the proportion of sexual abuse in infancy is three times greater for women drug addicts than for non-addicts and for SWIFT et al (96), it reaches 37% of the addicts in Australia. We have not found any study in Spain that analyses this in depth. According to the authors, this experience of sexual abuse in infancy, exercised on the majority of occasions within the family environment close to the girl, may be a predisposition to alcoholism and/or to drug dependency.

In women, the association between addictive disorder and psychopathic traits generally has a close relationship with antecedents of sexual abuse, rape and ill-treatment in comparison with non-addicts but when they are compared with male addicts, the probability that stressful events are related with initiation into drugs is also higher (MILLER 97).

According to a recent NIDA publication, women who frequently take drugs of abuse present antecedents of physical and sexual ill-treatment, which can reach 70%. They generally have little self-love, little confidence in themselves and may feel themselves powerless to face their own life. If, in addition, they belong to an ethnic minority, the cultural and linguistic barriers make their treatment difficult and worsen the prognosis for their addiction (NIDA 01). What we observe from this description is a person who feels incapable of leading her own life, a person with a tendency to affective or relational dependence in practically all spheres.

SIRVENT (95), alluding explicitly to the psycho- and sociogenesis of drug addiction, broke down a number of factors and among them one specifically for women: the "codependence" factor which acquires special importance when it comes to understanding the relationship between women and drugs.

We understand codependence as a relational dependency, secondary to addictive disorders (particularly drugs and alcohol) and which has its origin in the description of the pathological link that characterises the relationship of certain people to drug abusers, normally the closest family members and, above all, partners (SIRVENT 00). This role of double dependence, typical of the woman heroin addict relegates her to a subordinate role to her male and addict partner who is the one with whom she maintains the double dependence - on him and on heroin (LLOPIS 97).

Pursuing this line, one of the questions which stands out in the social analysis is the existence of the universality of female subordination, extending above and beyond cultures. Professor Gonzalez de Chavez notes what she calls the "interiorisation of domination" and which defines the fact that it is the women themselves who take upon themselves this differential categorisation of qualities and defects assigned to the psychological gender. "The interiorisation of the domination presupposes, on the one hand, respect for and identification with the values of the dominant group experienced as their own and, on the other, the conformation of the adaptive psychic structure and of placatory behaviours towards the group in power." (GONZALEZ de CHAVEZ 92)

In an analysis of circumstances or factors related to addiction in women, BUCKSTEIN et al (89), in a work on comorbidity between substance abuse and other psychopathologies, highlights hyperkinesia as a risk factor, principally for the behaviour disorders associated with it, and the relationship between food behaviours and addiction, without demonstrating if this is derived from the personality type of these patients or the affective disorders that are generally concomitant with bulimia-anorexia. Other studies also support this relationship.

HUSEMAN et al (90) raises the hypothesis that the habitual behaviours of "bingeing" and behaviours directed at reducing weight are associated with an increase in the plasmatic levels of beta-endorphins, in such a way that experiencing the effects of this hyperactivity of the endogenous opioids could lead to a self-addiction.

Pursuing the same line, KATZMAN et al (91) examined all the histories of women hospitalised for opiate dependency in a centre in New York, finding that, prior to abusing drugs, close to one quarter of them had suffered from bulimia nerviosa which, in addition, showed a tendency to reappear during detoxification periods. In their opinion, it is possible to establish a biographical sequence in these addicted patients: very active adolescents who sporadically show bulimic behaviours, later take cannabis, put on weight and a persistent behaviour of inactivity appears and, it is from this point that behaviour aimed at losing weight begins, often with provoked vomiting and the abuse of laxatives. Subsequently, they move on to the use of opiates, rapidly developing dependency, a reduction in weight and a drop in their preoccupation with it.

CASASNOVAS et al (96) carried out a study on selfmedication and drug use in university students of both sexes, finding significant differences in respect of gender. Differences that centred on the higher tendency of the girls to selfmedicate to mitigate pain and discomfort compared with the psychoactive use of drugs by the boys.
DEYKIN et al (92) published an extensive work with 233 alcohol or drug dependent adolescents in whom they found antecedents of primary depression or prior to the addiction. This had the typical characteristics of these disorders in adolescence, female sex, one parent with emotional or psychiatric problems, and victimisation. According to WEISS et al (92) women selfmedicate their depressive symptoms whether they have major depression or not whereas the men do so only when major depression exists. The association between drug abuse and depression was the most important in a study on dual diagnosis and predominated, most of all, among women who were abusing psychodepressive substances (GRANT 95).

In 1994, the NIDA published a wide ranging report on women and drug abuse in which, in addition to pointing out essential points in understanding the woman addict, it states that women who abuse drugs frequently present a low self-esteem, little confidence in themselves and feelings of weakness, in addition to feelings of loneliness and isolation from social support (NIDA 94).

MORALES et al (92) study the evolution of alcoholism in women, pointing out that in women's initiation into consuming alcohol, there is a higher socialisation as a determinant factor, which would correspond with the changes in the evolutive cycle

indicated above. The same work, however, highlights the restoration of the classic behaviours of the alcoholic woman (solitude and clandestine) when the use becomes pathological. After reviewing the evolution of her social role during the last few decades, there is no doubt in our minds of the importance of the structure and management of social networks for the woman addict.

A short time ago, Dr. Martens drew up a magnificent description of the characteristics of women treated in therapeutic communities in Belgium, of which the most notable are as follows (MARTENS, 99):

- persons with a character and sexual disorder, in that the majority have suffered from sexual abuses and/or have prostituted themselves during their active addiction period;
- tendency to self-contempt;
- high incidence of food disorders of the anorexia-bulimia type;
- psychological problems that are described as difficulty in self-assertion, in negation, and in setting their limits;
- at an emotional level, problems in feeling and expressing anger;
- in the cognitive sphere, they have a triple negative self-image. As addicts with character disorders, and being a woman;
- they experience discomfort with intimacy without sex and sex without drugs.

As we see, addiction in women may have much to do with determined disorders - depression and post-traumatic stress- that are more frequent or difficult to diagnose in feminine evolutive development. What does seem clear is that there are no big differences in the stereotypes that all societies have been assigning to women throughout history. As PARKER and WILHELM (95) point out, when a woman experiences depression, her symptoms are more easily incorporated within the coordinates that define the depression than in the case of a man suffering from that depression.

A review of the studies on personality in women addicts.

Focusing on the personality questionnaires, if we earlier observed the difficulty in having homogeneous criteria in the studies of the personality of addicts in general, the difficulties augment if we attempt to make an analysis of the literature dealing with women only. Specific personality studies of women addicts are not excessively abundant. The majority of the research works on personality are based on clinical impressions or even on evaluations made during the treatment for addiction. Added to this, we have to say that the works that include a control group which could be denominated as population within the definition of “normality” are few. Finally, when mixed samples are studied (men and women) and not men alone, the results are not generally differentiated on the basis of gender.

DUTHIE in 1980 working with women drug dependants who were following an outpatient treatment of methadone maintenance, examines their personality traits utilising a multivariate analysis through the MINI-MULT and finds that more than one half of the women present pathological profiles (DUTHIE 80).

SNYDER et al (85) described a significant difference in the MMPI substance abuse scales in respect of gender. The women addicts registered consistently higher scores than the men on all these addiction scales with the exception of the MacAndrew Scale.

ESBAUGH and KARL (82), also using the MMPI, carried out one of the most comprehensive works that we have examined on women addicts, finding that the most common personality profile consists of an elevation on the Pd scale and secondarily on the D scale. WALFISH et al (90), however, highlight the Pd and Ma scales as clinically significant elevations in women cocaine addict patients.

ANGLIN (89) makes an examination of studies made with the MMPI on addicts, and points out that the majority of authors find similar profiles in men and women, with peaks on the Pd and Ma scales which coincides with the data from the work by Walfish et al., although he also cites authors such as Olson who, in 1964, found lower scores for women on the K scale and higher scores on the D and Pa scales for men.

NACE et al (91) study a sample of 100 addicts in which the majority were men and found a predominance of personality and depression disorders. Quite a few years earlier, BERZINS (74) had already pointed out the elevations on the Pd and Hs of the MMPI as characteristic elevations and as the personality traits in addicts.

The differences between sexes for the alcoholic population show the higher presence of paranoid traits among alcoholic women on the MMPI scales (PEREZ and DE VICENTE 90; SVANUM and McADOO 91). Higher elevations on the Hs, Sc and Si scales for women, with elevation of FAM and reduction of REL, Mac Andrew, FEM and Mf, in respect of the men (PEREZ and DE VICENTE 90; SVANUM and McADOO 91).

More recently, DONOVAN et al (98) carried out discriminant analysis utilising the MMPI and did not observe differences between men and women, with predominance in both sexes of depression and psychopathic deviate traits. They recommend that these variables should be taken closely into account when planning therapy.

The few published studies using the Mini-Mult questionnaire show disparate results but coincide on the presence of two high scales: D and Pd. Thus, FACY et al (87) pointed out the psychopathic profiles as the most discriminant in women addicts followed by the depression profile, but for the men, however, the most discriminatory was the depression trait.

In 1992, we began our research work in which we endeavoured to study different aspects related to the use and addiction of drugs in women and the peculiarities of gender, and we published a comparative study of personality traits in two samples of women addicts. One was a sample of women alcoholics and the other of women addicted to heroin whose profiles were compared with a control group of women with no addictive pathology. In the results, we found very similar profiles for both groups of

addicts with elevations on the Depression, Psychopathic Deviate and Psychoticism scales, statistically significant in respect of the control group of women with no pathological profiles who for their part had significantly lower average profiles. The trait that differentiated the two groups was the high elevation on the Paranoidism scale in the group of alcoholics in comparison with the group of women heroin addicts (LLOPIS et al, 92).

TORRES et al (96) study the personality traits of addicts in respect of the criminality indices, using the MINI-MULT, and observe a profile that does not differ to a great extent when relating it to the gender variable and which is characterised by elevations on the D, Hy, Pd and Sc scales.

As we can appreciate from the biographical review, the constant in all the studies undertaken with women addicts utilising the MMPI, or its short forms, is the elevation principally on the D and Pd scales, although we have not observed unanimity among the authors reviewed in respect of the elevation of the remaining scales

As for the use of other questionnaires or instruments to measure personality traits with women addicts, this has been very variable, utilising the type normally to be found in this kind of research. There is also the problem of the extreme scarcity of publications referring specifically to women drug dependants.

RUNESON (90) studying young people who had attempted suicide, utilising the standard diagnostic interview with DSM III-R criteria, finds a higher diagnosis of drug dependency with some concomitant personality or effective disorder in the women, with a lower presence of dual diagnosis in the men.

MIRIM et al (91) using the same diagnostic instrument finds a predominance of affective disorders in addictive women. BRADY et al (93) study a group of alcoholic women and compare them with another group of alcoholic men. The authors observe that the alcoholic women present substantially higher indices of psychopathology that the alcoholic men, particularly in levels of anxiety, and that these differences are consistent with the prevalence of the same disorders in the general population.

In Spain MARTINEZ HIGUERAS (93) utilises the SCL-90 and compares the results on the basis of gender. In her results, she observes that the women addicts score higher than men on the Depression and Hostility scales and they also show more symptoms than the men in the overall indices and they show their malaise, intensifying the symptoms to a greater extent than the group of men addicts.

ÁLVAREZ et al (95) utilise the STAI to measure the level of anxiety in women addicts and find that the women addicts in their sample present higher anxiety levels as well as anxiety trait in comparison with the men addicts.

PONS and BERJANO (97) use the PNP questionnaire to carry out a comparative study on a group of women addicts and a control group in which they observe the possible existence of a relationship between addiction and the manifestation of pathological tendencies. Among the addicts in their study, there is a notable tendency to

present personality traits of a neurotic and psychopathic type traits that, according to the authors, would be central in understanding drug abuse behaviour among women.

In a study by NADEAU et al (99), they use the MCMI questionnaire to compare the personality traits of men and women drug addicts and find that the average pathological scores were significantly higher in the women.

Recently PETRY and BICKEL (00) evaluated the gender differences in hostility traits with drug dependants undergoing outpatient treatment. They measured the hostility with the Buss-Durkee scale, on which the women scored significantly higher and, in addition, it had a significant association as a predictor of early abandonment of treatment, something which did not occur with the men patients.

The research team of Professor Bobes in a study of recent publication, measures personality traits in Spanish students with multidrug use on the EPQ-A and the Sensations Seeking Scale. The multidrug user girls presented significant differences from those girls who were only experimenting or had never taken drugs, presenting a higher neuroticism and psychoticism. The differences in respect of sex appear in a higher score by the women in neuroticism and lower in sensation-seeking in comparison with men addicts (SAIZ et al. 01).

Another of the differential circumstances that appear associated to addiction in women is the higher prevalence of dual diagnosis and, most of all, the level of affective and anxiety disorders (KUBICKA et al 93; BLUME, 94; ETTORRE, 96, DONOVAN et al 98,). Addiction to alcohol/drugs has been postulated as having a relationship with almost all the psychiatric pathology, most notably anxiety and affective disorders (of higher prevalence in the women), behaviour disorders, antisocial personality disorder (more frequent in men) and other disorders such as hyperkinesia, the minimum cerebral dysfunction that sometimes accompanies it, food behaviour disorders (with a higher preponderance of the female sex) and even schizophrenia and other psychotic disorders.

Ignoring the possibility of a dual diagnosis and therefore the existence of a psychiatric comorbidity is, inevitably, going to affect the evolution and prognosis of the therapeutic intervention (SZERMAN and DELGADO, 94). It is for this very reason that SMITH and HUCKER (94) propose refresher courses for professionals on an approach to dual disorders and to reviewing the evaluation and admission criteria in programmes, in such a way that any relapse -particularly in psychotics- is not used as a criterion in limiting access to treatment resources.

WEISS et al (92) propose using the distinction between primary and secondary forms of depression in such a way that it would clarify the key aspects of the diagnostic process of the addiction and, in this way, be better adapted to the conceptual schema of psychiatry. According to some authors, dual disorders are not very prevalent when the sample is extracted from a drug addiction unit but are, however, very high when extracted from a psychiatric unit (RASKIN y MILLER 93), results that would support the hypothesis of selfmedication along the lines of the use of psychotropics to palliate the subjacent underlying psychiatric symptomatology.

The opiates and opioid peptides have shown antipsychotic properties but it is not demonstrated that schizophrenic patients use opiates and/or benzodiacepines to a greater extent than other populations (NOGUERAS et al, 93) and, in a certain study, the authors even find higher rates of hallucinogen and amphetamine abuse among schizophrenics compared with a general population group, and lower rates in the use of cannabis, sedatives and narcotics (MUESER et al, 90), although it is true that these data would appear to be more of an exception that the rule.

DEYKIN et al (92), studying 222 adolescent Americans drug dependants, find a prevalence of depression that is three times higher than that of non-addict adolescents. The authors find that in 28% of those who suffer from depression, this occurred prior to the addiction, in 40% it was posterior, and in 20% the depression and addiction commenced together. The characteristics of the primary depressions were: female sex, psychological problems in one parent and victimisation from antecedents of physical or sexual abuse.

BRADY et al (93) studied comorbidity in adult addicts on the basis of their gender and found that the men presented a significantly higher prevalence of alcoholism, and the women other DSM III-R Axis I disorders, in addition to the addiction, particularly affective and anxiety disorders but, on the other hand, they point out that these differences in gender do not differ substantially from the prevalence of these same pathologies in the general population, which corroborates the theories set out by RASKIN and MILLER (93).

The prevalence of depression in women in Spain is approaching double that of men, firstly, as the result of a greater sociocultural acceptance of the problem in women and, secondly, the much more frequent possibility for the man of manifesting the affective disorder through aggression or alcohol abuse (FUERTES and CABRERA, 96). In the case of Antisocial Personality Trait (APT), the prevalence among men in Spain is three times higher than that of women (1%), and the problematic is to establish the dividing line between adolescent conflict and Antisocial Personality Trait (APT) when, at their onset, both disorders can share certain similar behaviours (FUERTES and CABRERA, 96).

The comorbidity between mental disorder and drug abuse presents differences in the results according to the gender of the addict, insofar as APT predominates among men, and depression and post-traumatic stress disorder among women (LESHNER 99). In addition, NOVINS et al (96) find that women present greater associations between depressive symptoms and drug abuse with a very much higher prevalence than that in men and in the general American population. These data however present variations according to the source of the sample being studied, as we have mentioned above. In the American ECA study, in reference to the data on transient or homeless women, it points out that the APT prevalence is high and is also associated with a more than double the probability of accomplishing a dual diagnosis of addiction compared with women with no APT criteria (SMITH et al 93)

In order to prevent diagnostic confusions and oversights in therapeutic planning, certain methodological considerations in Dual Diagnosis have been proposed, most of

all in affective disorders and post-traumatic stress which is more prevalent in the woman addict, and in APT which is more prevalent in the male drug dependent (ALTERMAN and CACCIOLA, 91. WEISS et al 92; LESHNER 99).

- Delaying the interview until a certain physical and psychological stability is achieved.
- Corroborating data with information obtained from family and relations.
- Utilising standardised instruments in order to evaluate the addiction and psychiatric disorders.
- Being clinically trained to carry out the personal interview.
- Following the patient longitudinally, as temporal stability of the diagnosis is moderate or low.
- Repeating the interview throughout the follow-up and with the patient already stabilised with the symptomatology of addiction or abstinence.
- Contrasting the APT diagnosis with other researchers in that the reliability between researchers is lower than one would wish in addict populations.
- Not raising assessment criteria at the beginning, as a differential prognosis has not been shown in respect of other addicts without comorbidity.
- In the case of APT, delimiting the temporal sequence of the same in that there exists evidence of psychiatric heterogeneity among the addict group with APT.

As conclusions, we observe that the majority of the authors reviewed point to the existence of certain personality traits conducive to developing an addiction but, at the present time, there is no scientific evidence that sustains the concept of addictive personality. Addiction is a very complex and multifactoral process in which determined personality characteristics may be constituted as factors of vulnerability to the development of this disorder but always with one etiopathogenic element more. Some people need very new and exciting experiences, other feel a rejection of the imposed social norms, and these may be more susceptible to the development of an addiction to drugs influenced by the agreeable sensations that they induce. Other people may use psychotropic substances to selfmedicate certain disagreeable or dysphoric moods and, in the majority of cases, quite possibly both these motivations end up intermingling.

In the case of the woman, the psychiatric comorbidity of the addiction acquires differential characteristics that very often stem from the incidence of the primary affective disorder and the impact of chaotic interpersonal relationships in early stages of their development. A lack of understanding of these factors, leaving them outside therapeutic planning, provokes a lower access to treatment by the women, a higher rate of abandonment and, in addition may reduce the efficacy of the treatment (HAGAN et al, 1994).

Methodology

Having seen the antecedents in the studies reviewed and the frequent disparity of opinion on the existence of personality traits linked to addiction, we decided to carry out fieldwork that would enable us to evaluate personality traits in women addicted to opiates who were attending a alcoholism and drug dependency unit.

Therefore, we drew up a study to evaluate the personality traits in women diagnosed with opiate dependence syndrome who had been attending the Alcoholism and Drug Dependency Unit in Torrent, Valencia, since 1992, the point in time when it began a systematic evaluation of personality characteristics in patients attending the Unit using the Mini-Mult (KINCANON 68). This Questionnaire is a shortened version of the MMPI with 71 items focussing on the subtle aspects of maladjustment corresponding to the traditional psychiatric syndromes thereby permitting the measurement of psychopathological traits in the patients.

The questionnaire presents a characteristic that was influential in our deciding on its systematic utilisation with our patients: administered in oral, self or hetero form it enables questionnaires to be used with illiterate population, the blind, those with low intellectual capacity and with people presenting a deteriorated or reduced cognitive state caused by drug use. In addition, the brevity of the questionnaire compared with the MMPI enables us to make a rapid assessment, by way of screening to complete the psychiatric clinical observation.

In our research, Cronbach's alpha gave it a reliability of 0.828, which reflects a high reliability.

In order to obtain the central sample for our study, we collected data pertaining to 130 women opiate addicts who had been treated in the Unit and had been undergoing treatment and follow-up for enough time for us to be able to evaluate their data.

We used a methodology of controlled cases with an expost-facto experimental design of a longitudinal type carried out on cohorts in which we did not control the principal variable of exposure to the risk factor - addiction. We should like to point out that the data we obtained refers to people with several years of addiction with, in many cases, several earlier treatments and, without a doubt, with a deterioration in social and personal aspects that we think is reflected in the results of the sample of addicts.

In order to be able to carry out the comparative study, we selected samples that we used as control groups, through random selection of a control subject for each case, comprising 130 male patients addicted to opiates, receiving attention in the same drug dependency unit, and who presented an distribution equal to that of the group of women in respect of their relation to the selection variables. Our sample made it possible for us to be able to compare the personality traits of the addicts in respect of their gender.

Moreover, we wanted to know if the personality traits of women addicts presented the peculiarities typically attributed to the gender or if, on the contrary, the addiction factor conferred specific and differentiating characteristics on them from those of the other women with no addictive pathology. To do so, we utilised a second control group comprising 130 women with no antecedents of addiction or psychopathology.

It must be pointed out that we could only carry out the test-retest evaluation with a part of the sample of the male/female addicts, comprising an N of 71 cases and which we will call the "subsamples of addicts". In the total of the sample studied, only the results of the first Mini-Mult were evaluated. This is why we will give an initial description of the scores obtained on each one of the scales and the profile obtained for the samples in the first test. Subsequently, we will make a comparative analysis of the samples of women and men opiate addicts on whom we were able to carry out an evaluation on finalising the two-year follow-up with the profile obtained, from a second questionnaire.

The number of patients that did not complete the Mini-Mult is 7 (5'4 %).

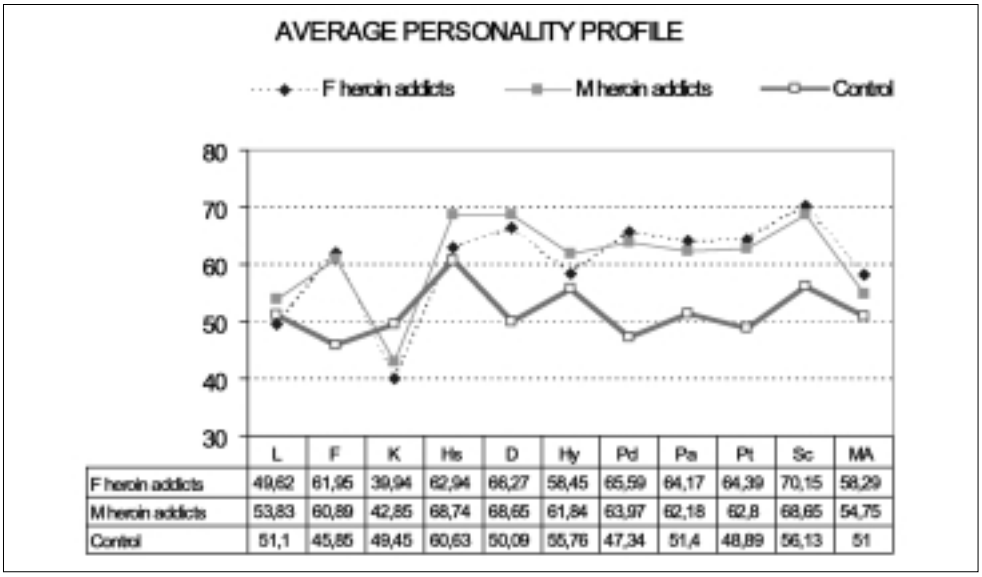
Personality profile sample women addicts, results

The elevation of the most notable percentiles on the different scales of the questionnaire show an 8-2-4 type profile, in other words, appropriate elevations on the Sc, D and Pd scales. This is a profile that corresponds to personality traits of the schizophrenic type and sociopathic tendencies with levels of pathological anxiety.

In parallel with the principal Mini-Mult scales, we studied the results on Welsh's Anxiety Index, obtained through scores registered on the scales of the test. The average score obtained is pathological (71.96) and reflects a high rate of anxiety, with 54.3 % of the questionnaires having pathological scores that reach the maximum range of 100.68.

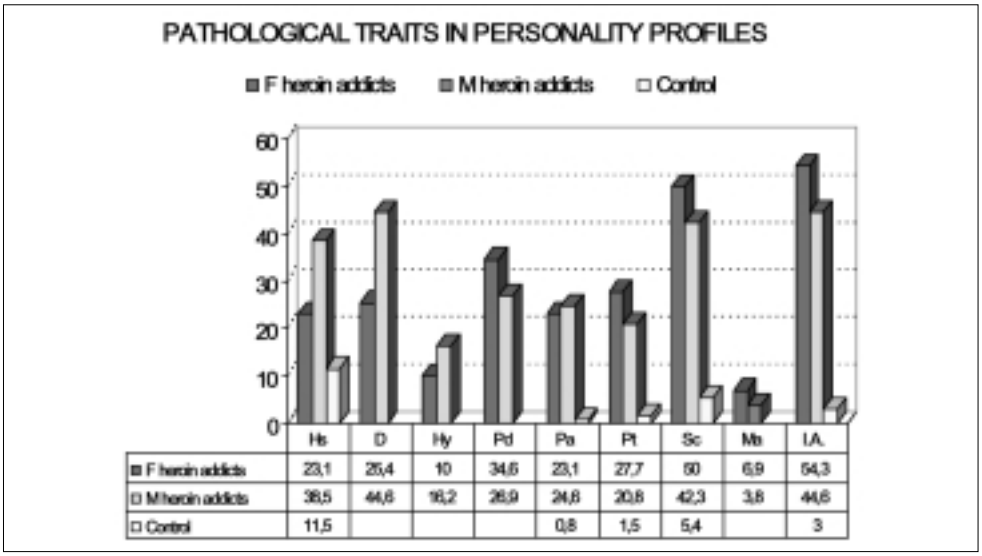
VALUE OF THE FIRST MINI MULT SAMPLE WOMEN OPIATE ADDICTS

	NS/NC.%	< or=69%	>or=70%	AVERAGE	D.S.	MODE	RANGE
L SCALE	5,4	94,6	0	49,62	7,08	48	40-68
F SCALE	5,4	60,8	33,8	61,95	13,73	54	37-96
K SCALE	5,4	94,6	0	39,44	8,32	37	25-65
Hs SCALE	5,4	71,5	23,1	62,94	9,33	59	46-87
D SCALE	5,4	69,2	25,4	66,27	7,88	69	46-82
Hy SCALE	5,4	84,6	10	58,45	11,05	66	30-78
Pd SCALE	5,4	60	34,6	65,59	9,88	55	34-84
Pa SCALE	5,4	71,5	23,1	64,17	9,74	64	39-88
Pt SCALE	5,4	66,9	27,7	64,39	8,41	67	39-79
Sc SCALE	5,4	44,6	50	70,15	10,73	74	36-92
Ma SCALE	5,4	87,7	6,9	58,29	8,86	63	37-76
ANXIETY INDEX	5,4	43,1	54,3	71,96	16,76	81,23	22,46-100,68



	L	F	K	Hs	D	Hy	Pd	Pa	Pt	Sc	MA
F heroin addicts	49,62	61,95	39,94	62,94	66,27	58,45	65,59	64,17	64,39	70,15	58,29
M heroin addicts	53,83	60,89	42,85	68,74	68,65	61,84	63,97	62,18	62,8	68,65	54,75
Control	51,1	45,85	49,45	60,63	50,09	55,76	47,34	51,4	48,89	56,13	51

The personality traits offered by each of the samples present obvious statistically significant differences. Whereas the average personality of women heroin addicts is of the 8-2-4 type (elevation on the Sc, D and Pd scales) of the schizoaffective type with sociopathic tendencies, added to which, they present the highest anxiety level of the three samples (71.96), among the male heroin addicts, there is a notable average profile of the neuroticism type and depressive symptomatology, with elevation on the Hs, D and Sc scales (1-2-8 profile), with the addition of elevation on the Anxiety Index (67.18). As was to be expected the average profile of the sample of women in the control group is unspecific with parameters of normality in percentiles close to T=50.



	Hs	D	Hy	Pd	Pa	Pt	Sc	Ma	I.A.
F heroin addicts	23,1	25,4	10	34,6	23,1	27,7	50	6,9	54,3
M heroin addicts	38,5	44,6	16,2	26,9	24,8	20,8	42,3	3,8	44,6
Control	11,5				0,8	1,5	5,4		3

The percentage of cases with pathological scores on the different scales is high, particularly on the Sc scale (50 % for the women and 42 % for men), Pd (35 % women and 27 % men), Pt (28 % women and 21 % men), D (25.4 % women and 44.6 % men), Hs (23 % women and 38.5 % men) and on Welsh's Anxiety Index (54 % of the women and 44 % of the men). On the validity scales, only the F scale showed pathological scores in 34 % of the women and 27.7 % of the men.

The results of our study in the section on personality are not totally comparable with those by other authors given that the majority of the publications reviewed do not indicate the time at which the psychological exploration took place. In this type of studies, therefore, it is not possible to control the influence of extraordinarily influential variables on the psychological state of an addict, such as use, presence of abstinence syndrome or a state of prolonged abstinence. Nevertheless, and to make a comparison, we must suppose that the majority of the questionnaires were answered at the beginning or at least in the first phases of treatment, given that they are instruments of pretherapeutic diagnosis aid.

Our results coincide qualitatively with those of SOLER INSA and GRAU (88) who point out the predominance of affective disorders of a depressive type and personality disorders as being the most frequent in heroin addicts. The personality trait characteristic most associated with substance abuse is, according to the majority of authors, psychopathy or antisocial personality (FERNÁNDEZ et al, 96). ROUSANVILLE et al (cit. in SOLER INSA and GRAU, 1928) in a review of three thousand addict subjects, found that depressive and psychopathic disorders predominated. CARCAS et al (89) in our country, coincide, pointing out the importance of the depression-anxiety factor in the personality characteristics of heroin users. MILLER (90) states that, in drug dependants, there is an increase in disorders of an impulsive nature, followed by depressive and anxiety subgroups, data with which MAGRUDER-HABIB (92) partially coincide, when pointing out that half of the addicts treated presented symptoms of depression or suicide, particularly the women and the multidrug users.

BLUME (89) considers that no simple personality factor can be considered a necessary or sufficient condition for the development of substance abuse disorder. FERNÁNDEZ GÓMEZ et al (96), in a review of personality in heroin addicts states that the different studies coincide in the acceptance of the heterogeneity of the personality characteristics of addicts more than on the acceptance of an addictive personality type.

WALFISH et al (90), employing the MMPI on 243 young drug dependants undergoing hospital treatment, found a important elevation of the psychopathic deviate trait. In another study in the same year, the same authors measured the anxiety and anguish between drug dependants and, on comparing them with adult population, the authors determined that the anxiety traits were higher among addicts in comparison with the non-addict population but they did not find any significant difference in the personality traits of heroin addicts and cocaine addicts.

SUTKER et al (79), in a comparative study of alcoholics and heroin addicts, observed how the latter registered higher scores on the Pd, Ma scales and the Es subscale, high scores predominating in the alcoholics on the Neurotic Triad (Hs, D and Hy) and on Welsh's Anxiety Index.

NACE et al (91), with a sample of one hundred addicts of both sexes, finds MMPI results similar to ours but with a higher percentage of pathological scores in personality disorder (57 %), followed by high scores on the depression scale. Practically the same profiles were observed by SHAFFER et al (88) among patients on maintenance with methadone, with elevations on the F, D, Pd, Pt and Sc scales.

ARIAS in 1995 carries out an analysis of the relationship between psychiatric disorders and heroin in Spanish patients undergoing treatment with Naltrexone. The author uses the MMPI questionnaire to evaluate the psychopathological traits and finds a profile with elevations on the D, Pd and Sc scales, with a 2-8-4 profile, practically identical to that of our study (ARIAS 95)

As for the works that analyse the psychological and psychopathological profiles in women addicts, our results differ completely from those observed by CERVERA (91) who considers that "the majority of women drug dependants present histrionic personality" in spite of the cliché that could be seen in this statement, it should be taken into account that the author is referring to DSMIII-R Axis II diagnoses and not to personality questionnaires.

BERZINS et al (74) in a study with women drug addicts, utilising the MMPI, find significant elevations on all the scales, notably the scores on Hypochondriasis (T=60) and Psychopathy (T=70). PIERRE and SILVIE ANGEL (cit. in FACY et al, 87), in their clinical experience with women addicts in France, record the predominance of the anxiety and depressive symptomatology, results that coincide with ours.

MARINA et al (96), utilising the GHQ, observe a higher frequency of pathological scores among the women (95.5 %) than in the men (58 %), in a sample of Spanish addicts. HAVILAND et al (94) find various psychometric values of depression and anxiety to be higher in women. Coinciding with this, and also with our results, ALVÁREZ et al (95) find higher levels among the women than the men, in drug dependants treated in a DRU. De LEÓN (89) also found greater symptomatology among the women.

ESBAUGH and KARL (82) made a very broad study of women drug addicts, utilising the MMPI, in which they found seven personality profiles. The most common consisted of an elevation on the Pd scale, which was found to be elevated in six of the seven proposed profiles. Among these profiles, the third group in frequency would coincide completely with that of our sample of women: elevation on the D, Pd and Sc scales. KUBICKA et al (93) carry out a study with Czech women drug users and find a close correlation between high anxiety levels, as in our sample, and use of ansiolytic and hypnotic medications, in addition to abuse of alcohol and opiates.

FERNÁNDEZ GÓMEZ et al (96) found in their sample of addicts in a T.C., a personality profile of 8-2-4, identical with that of the women in our work. In addition,

the women also present a higher percentage of pathological profiles, their percentiles being slightly higher than ours. The statistically significant differences between men and women in this work are produced on the D, Mf and Sc scales on the MMPI, these differences in depression and psychoticism coinciding with the majority of authors who point out greater symptomatology in women, and who generally interpret it as a consequence of the greater stigmatisation of women addicts derived in turn from the greater conflict in the social role linked to the gender.

The few studies published with the Mini-Mult test reveal disparate results. DUTHIE and BORRERO-HERNÁNDEZ (79) employ the Mini-Mult to differentiate heroin addict outpatients from psychiatric patients and normal population. They carry out a discriminate multiple analysis and obtain significant results on the L, F, Hs, D, Hy and Pd scales. Subsequently, DUTHIE (80) studies hospitalised women drug dependants and examines their personality traits using a multivariant analysis, finding 42 % normal profiles, 24 % with personality disorders, 6 % with neurotic traits and 28 % without classification but with pathological scores. FACY et al (87) find in male addicts under 20 years of age the depression variable as the most discriminant between drug addicts and the control group (very similar results to ours).

In Spain, the Mini-Mult has been used most of all with alcoholics, and the published studies reveal pathological profiles, mostly as a result of the elevation on the depression scale (RAMÍREZ et al., 90). MONRAS and SALAMERO (87) find elevated scores on the F, D, Sc, Hs and Pt scales in alcoholic patients. A very similar profile to the one we obtained with women drug addicts, with the exception of the Pd scale.

In 1992, we published a comparative study on personality traits in women drug addicts, alcoholics and controls using the MINI-MULT with samples from Castellón and Alicante. The profiles found are very similar to those of our female sample with slight differences between alcoholics and drug addicts in a common profile that could be conceptualised as the addictive clinical profile (elevation on the D, Pd and Sc scales) and slightly higher in the averages scores for the women heroin addicts. As a differentiating element, the alcoholic women registered higher levels on the paranoidism scale in comparison with the young heroin addicts (LLOPIS et al, 92).

Evolution of personality traits in the subsample of women addicts

We carried out a comparative study of the results obtained in the first Mini-Mult at commencement of treatment and on finalising the follow up at 2 years (2nd Mini-Mult) of a group of women addicts. Of the total possible questionnaires, we can only include the results of the two questionnaires for 66% of them, (Subsample) so that it is difficult to extrapolate the results to the total sample. This is the reason why we will limit ourselves to making a comparative analysis of the profiles of personality trait in this subsample, at commencement and at the end of the follow-up.

In the first questionnaire, we see that the average scores are slightly higher on the Hy (60.13), Pd (66.68), Pa (65.10) and Sc (71.55) scales than in the total sample of women addicts, and lower in the score on the depression scale (65.97). In spite of these

differences, we see that, once again, the personality profile is characterised by the same combination of elevated scales as in the overall sample although with an 8-4-2 profile (Sc, Pa and D).

If we compare the average scores on the first questionnaire with those shown in the second questionnaire at the end of the follow up, we see that there has been a drop in practically all, including the anxiety level. The elevation observed in the L and K scales on the second Mini-Mult would be a result of an increase in the sincerity and trust of the informant and the drop on the F scale would, for some authors, reflect a reduction in the intensity of the patient's symptomatology (PÉREZ and De VICENTE 94). We see a rise in the Hs and Hy scales that probably shows a certain tendency to preoccupation with their health and a tendency to clinical manifestation of organic problems and sensations of tension and fear. These scales, together with the elevations on the D scale, comprise what is known as the Neurotic Triad. In the case of the Mini-Mult, at the end of the follow-up, we find all the average percentiles within normality, with predominant elevation on the Sc scale.

In other words, a drop in the average score on the scales is occurring during the follow-up, showing a similar profile to the commencement but with a tendency to normalisation.

The differences found in the evolution of the average scores on the L, Pa, Pt, Sc and Ma are statistically significance which has a greater influence when looking at such scales as the pscychoticism (Sc) and the Anxiety Index which have shown a drop from the pathological scores (T>70) of the first test to high average scores, but still within normal range (Sc 67; A.I.62), at the end of the follow up.

We must emphasise that the small number of patients that make up the subsample with which we could carry out the test-retests do not permit us to extrapolate the results, in spite of their high statistical significance, to the total of the sample of women, object of this research.

PERSONALITY PROFILE SUBSAMPLE WOMEN ADDICTS		
	AVERAGE SCORES FIRST MINI MULT SCALES	AVERAGE SCORES SECOND MINI MULT SCALES
L SCALE	47.71	51.73
F SCALE	62.68	59.55
K SCALE	38.92	43.50
Hs SCALE	62	63.18
D SCALE	65.97	63.60
Hy SCALE	60.13	61.39
Pd SCALE	66.68	64.02
Pa SCALE	65.10	60.47
Pt SCALE	64.13	60.73
Sc SCALE	71.55	67.78
Ma SCALE	58.68	54.28
ANXIETY INDEX	71.58	62.63

Comparison of the evolution of the personality profile. gender differences on commencement and end of follow-up

The evolution of the personality profile throughout the follow-up demonstrates a tendency to a reduction in the pathological scores on practically all the scales including the Anxiety Index, for both men and women addicts. The tendency to normalisation of personality traits is greater among the men heroin addicts.

The pattern of the change in the personality profile presents significant differences on the scales:

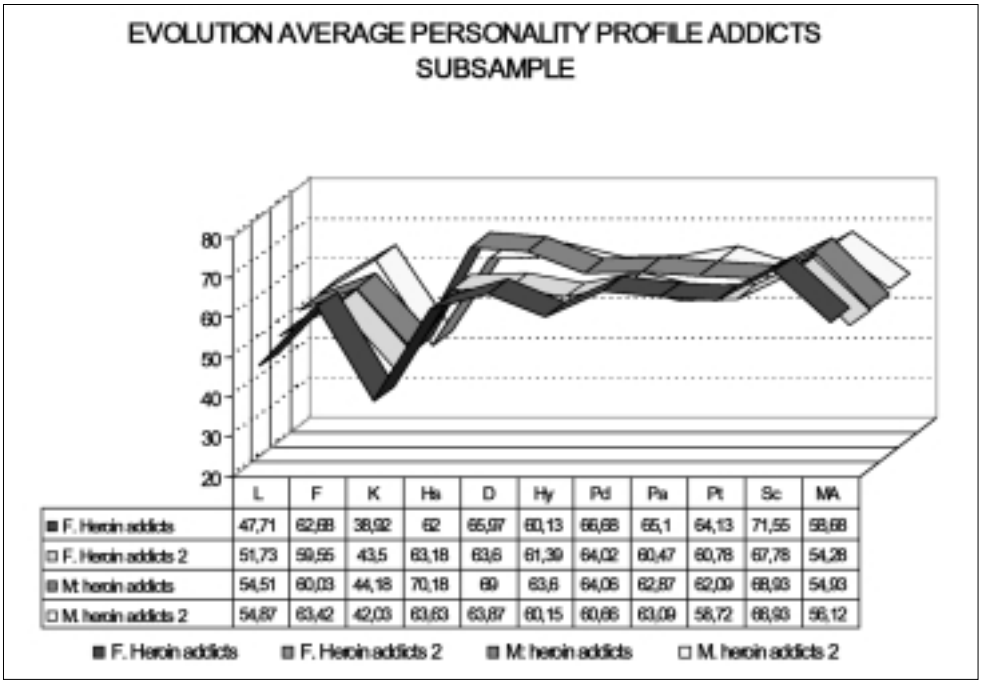
- L (P=0.013) with elevation in the profile at the end of follow-up, significantly higher than in the men;
- depression Scale (D) on which the descent in the average scores is greater for male addicts (P=0.011);
- psychopathic deviate Scale, (Pd) on which there is a significantly higher tendency to normalisation in men (P=0'019);
- Pt Scale or compulsive-obsessive traits, where once again, the difference is centred on a descent to normalised scores, predominantly in the men (P=0.007);
- psychoticism Scale, (Sc, P=0.035) like the preceding scale, and in spite of the big fall in the average scores of the women, the men continue to obtain a significantly lower score on the Mini-Mult in the final follow-up phase.

Welsh's Anxiety Index shows the same evolutive trend as the rest of the scales in such a way that the men tend to obtain more normalised average and statistically significant scores than the women (P=0.013).

In spite of the fact that it was only possible to carry out the follow-up and comparison of the personality profile at the commencement and in the final phase with a small part of the sample (N=71) -which does not enable us to extrapolate the results to the total of the population being studied - the high statistical significance of the comparisons enables us to state that a tendency to normalisation is observed in the average personality profiles in both samples of addict subjects, being significantly higher in the men. At the same time, there is an increase to be seen in the level of trust and sincerity in the responses, irrespective of the situation of use or abstinence.

The average personality profile obtained in the final phase of the follow-up does not show big differences between the two groups of drug dependants, both sexes presenting average scores of around 60 percent, except for the elevation on the psychoticism scale which, although it remains high, does not, at any time, reach pathological scores.

The evolution of the personality profiles in the subsamples studied from the commencement to the final follow-up stage reflects a clear improvement by the descent produced in the scales, with statistic significance, D, Pd, Pt, Sc and in the anxiety index. A notable tendency to normalisation of average scores is to be observed in them all. The personality traits of the two subsamples present the same profiles that we found in our overall samples, Sc, D and Pd in the women and Hs, D and Sc in the men.



	L	F	K	Hs	D	Hy	Pd	Pa	Pt	Sc	MA
F. Heroin addicts	47,71	62,88	38,92	62	65,97	60,13	66,88	65,1	64,13	71,55	58,88
F. Heroin addicts 2	51,73	59,55	43,5	63,18	63,6	61,39	64,02	60,47	60,78	67,78	54,28
M. heroin addicts	54,51	60,03	44,18	70,18	69	63,6	64,06	62,87	62,09	68,93	54,93
M. heroin addicts 2	54,87	63,42	42,03	63,63	63,87	60,15	60,66	63,09	58,72	66,93	56,12

This tendency to the normalisation of personality traits coincides with the results of SÁNCHEZ CARBONELL et al (88); MAGRUDER-HABIB (92); SHUFMAN (94), BOLINCHES (96) and with the results of PÉREZ GÁLVEZ and De VICENTE (94) in alcoholics studied with the MMPI. In addition to coinciding, MARINA et al (96) find that psychopathology was more prevalent among the addicts who continued to use drugs, particularly among the women.

As a far as the evolution is concerned, the results of the study by ARIAS (95) with patients of both sexes addicted to heroin undergoing treatment with antagonists differ from those in our work. Arias observes that the psychopathic and schizoids remain stable during the addictive process and after treatment, with little predictive power of response to therapeutic intervention whereas the depression scale is the most susceptible to temporal fluctuation and may reflect situational factors.

TORRES et al (95) also find falls in the scores on the Mini-Mult in a study of 115 heroin addicts of both sexes, pointing out that the changes in the personality profile may be determined by the use or non-use of substances and by the intervention with the patients in such a way that remaining in the programme would improve diverse factors that influence the changes in personality traits.

Subsequently, the same research team published another follow-up study of alcoholic patients and drug addicts (TORRES et al 97), measured with the Mini-Mult, where it showed the depression trait as a factor with very much higher than normal scores in 47% of those interviewed on commencement of treatment, falling to 40% of

them on a second evaluation at six months. According to the authors, this slight and not significant drop in the pathological scores would be indicative of stability in the depressive traits of the addicts. BELAUSTEGUI (00), in the study he carried out on personality in drug dependants of both sexes, supports these statements, considering that personality disorders that appear as a result of drug use are maintained after abstinence whether the disorder existed previously or was a consequence of the use.

They also find a certain stability in the pathological personality traits studies, such as that published by SAN NARCISO et al. (98) who study a sample of opiate addicts of both sexes through the IPDE throughout the rehabilitation treatment and find an incidence of personality disorders in 97% of the sample at the commencement of treatment, particularly disorders of an impulsive, antisocial and schizoid type. Six months later, all patients who were continuing in treatment presented at least one personality disorder but the scores had been reduced to a great extent in comparison with those of the commencement of treatment. In the population comprising the sample, the women presented lower scores in all the areas, and this coincides with our results.

FERNÁNDEZ GÓMEZ et al (96), however, are of the opinion that the changes in the personality characteristics at six months, found in their study, show the low temporal stability of the early diagnosis made with the MMPI. This relationship between the changes in the personality profiles and the low stability of an early diagnosis with personality questionnaires when really what it is reflecting would be the state of psychological stress to which the drug dependant is submitted at this stage. (De LEON, 89; BLUME, 89).

The increases observed in the F and Py Scales in women and in Hs in men in our study coincide with the pattern of change that was observed by FERNÁNDEZ GÓMEZ et al (96) indicating an increase in interpersonal implication. The drop on the D Scale (as in our work) would, according to the authors, be related to an increase in self-esteem and the disappearance of stress factors at the time of admission. The increase in the L and K Scales (something which also occurs in our sample) suggests a certain increase in defensivity and would be associated with a lower acceptance of socially undesirable traits.

CERVERA et al (98) coincide with our results in a study on risk factors in drug dependants when they point out that both the antisocial disorder and the borderline personality disorder improve notably as they evolve over time, underlining the need for the addict to be able to have all the therapeutic interventions possible in order to reduce the seriousness of the consequences of the addiction.

As for anxiety levels at the commencement of treatment and its evolution over time, the majority of the works we examined point out the elevated indices of anxiety as a reaction to the situation of stress that is being experienced at that point in time, and they coincide with us in emphasising the reduction of this figure throughout the treatment. In this way, studies carried out with patients undergoing treatment for rehabilitation with naltrexone find a prevalence of pathological anxiety of 5% at commencement of treatment that goes down to 1% after the first month of intervention and continues to fall until it disappears in the assessment made after 6 months (OCHOA 99).

In the study carried out with patients addicted to opiates in the outpatients section of the Department of Psychiatry at the University of Vermont (PETRY y BICKEL 00), the hostility trait is shown as a differential trait between the sexes and, in addition, the highest levels of hostility predicted premature termination of treatment in the women together with the severity of legal and employment problems. With the men, however, the hostility levels were not associated with premature termination of treatment.

Possibly, determined personality traits at the commencement of treatment are more determinant in women and, at the same time, their stability throughout treatment is not very high so that the improvement in the anxiety, depression, hostility and other traits have a decisive repercussion on the therapeutic results.

Conclusions

In spite of the fact that various factors related with personality are shown to be decisive in the development of an addiction, the studies have not yet been shown to be conclusive in respect of the existence of a preaddictive personality.

Traits such as antisocialness, sensation-seeking, depressivity and the consequences of post-traumatic stress seem to be determinants in the structure of the personality of drug dependants.

Personality diagnosis in addicts encounters serious difficulties arising from the methodology, the criteria and diagnostic instruments at the time of the assessment and also in the duration of the follow-up of patients.

A large part of the studies coincide in highlighting a number of personality traits common to addicts and which appear to be the result of the evolution of the addiction and the years of addictive behaviour.

The study of personality in the addict population has been carried out with a variety of diagnostic questionnaires, most notably the MMPI. The majority of the results coincide in highlighting the elevations on the D and Pd scales as predominant personality traits above the percentiles for normality.

In women drug dependants, in particular, the importance of determinant factors in their addiction that have direct repercussions on their personality was observed.

The social incorporation of women and the collision with the archetypes of a sexist education lead to maladjustments in the structure of the personality of the woman who may find alleviation of her internal discomfort in the use of drugs.

The differences in personality between men and women addicts centres around the importance of the dependant personality traits, codependence, post-traumatic stress as a consequence of sexual abuses and depressivity as determinants in the women whereas the antisocial and sensation-seeking traits have a greater weight among the men.

The profile of personality in the women heroin addicts in our study is characterised by an elevation on the Sc, D and Pd Scales together with pathological scores on the Anxiety Index, configuring a schizophrenic profile with psychopathic tendencies.

The differences in personality traits between men and women addicts in our research are centred around: a higher anxiety index and schizophrenic profile in the women against neurotic-type personality with elevations on the Hs, D, and Sc Scales.

The women in the control group of non-addicts show a significantly different personality profile from the groups of addict population, and in which we did not find any pathological elevations.

The personality profile in the woman addict is not modified substantially over the time of treatment but it does show a tendency to reduction in the pathological scores on all the scales, including the Anxiety Index. At a 2-year follow-up, all the personality profile scales show scores within normality.

Continuing with treatment has a very positive effect on personality traits in addicts, provoking a tendency to normalisation. This tendency to normalisation, of what, at commencement of treatment, were pathological personality traits, is significantly higher in men than women drug dependants.

Determined personality traits at commencement of treatment are more determinant among the women addicts than among the men. The stability of these traits over time is low with an improvement in the pathological aspects which has a decisive repercussion on the results of any therapeutic intervention.

Given the scarcity of specific studies of women addicts, there is an obvious need to carry out much broader research that studies factors linked to addiction, such as the personality both prior to the commencement of the addictive pathology and afterwards. In carrying out these studies, the utilisation of standard diagnostic criteria is essential, with instruments internationally assessed and accepted and with longitudinal and comparative studies with control groups.

References

Alterman A. Cacciola J. S. (1991) *The antisocial personality disorders diagnosis in substance abusers, problems and issues.* J. Nerv. Ment. Dis. Vol. 179 (7), pp. 411-409.

Alvarez Navares A. et al (1995) *Valoración del funcionamiento de una unidad de desintoxicación a lo largo de cinco años.* En Mateos Agut, et al (ed): "Los equipos interdisciplinares en drogodependencias: estructura, estrategias y evaluación", Burgos, pp. 251-268.

Anglin M. D. et al. (1989) *The MMPI profiles of narcotic addicts. I. A review of the literature.* Int. J. Addict., 24 (9), pp. 867-880.

Arias F. (1995) *Trastornos psiquiátricos en dependientes a opiáceos en tratamiento de mantenimiento con Naltrexona.* Tesis doctoral. Universidad de Alcalá de Henares.

Arias F. (1999 b) *Trastornos de personalidad y dependencia de opiáceos.* Monografías de Psiquiatría, Vol. XI, n. 4. 30-40, 1999.

Arias F. (1999 a) *Trastornos psicóticos y dependencia de opiáceos.* Monografías de Psiquiatría, Vol. XI, n. 4, pp. 2-16.

Astin A. (1959) *A factor study of the MMPI psychopatic deviate scale.* Journal of Consulting Psychology, 23, pp. 550-554.

Belaustegui R. (2000) *Prevención, personalidad y drogodependencia: Análisis clínico de la personalidad en una muestra de drogodependientes.* Rev. Esp. Drogodep. 25 (1), pp. 57-64.

Berjano E. Musitu G. (1987) *Las drogas. Análisis teórico y metodos de intervención.* Nau Llibres, Valencia.

Berzins J. I. Ross W. F. English G. E. (1974) *Subgroups among opiate addicts: a typological investigation. J. Abnorm. Psychol, 83 (1)* pp. 65-73.

Block J. Block J. H. Keyes S. (1988) *Longitudinally foretelling drug usage in adolescence: early childhood personality and environmental precursors. Child Development No 59,* pp. 336-355.

Blume S. B. (1989) *Dual diagnosis: Psychoactive substance dependence and the personality disorders. Journal of Psychoactive Drugs. Vol 21, No. 2,* pp. 139-144.

Blume S. B. (1994) *Women and addictive disorders. American Society of Addiction Medicine 1994,* pp. 1-16.

Bolinches F. et al (1996) *Valoración psicopatológica al inicio y a los seis meses de pacientes dependientes a opiáceos en tratamiento ambulatorio. En XXIII Jornadas Nacionales de Socidrogalcohol. Libro de Actas,* pp. 447-450. Ed. Socidrogalcohol. Oviedo.

Brady K. T. et al (1993) *Gender differences in substance use disorders. American Journal of Psychiatry. 150 (11).* 1707-1711. 1993

Brooner R. et al (1993) *Antisocial personality disorders amog drug abusers: relations to other personality diagnosis and the five factors model of personality. Journal of Nervous and Mental Disease. 181 (5),* pp. 313-319.

Buckstein O.G. et al (1989) *Comorbidity of substance abuse and other psychiatric disorders in adolescents. Am. J. Psychiat., 146 (9), pp.* 1131-1141.

Cabal Bravo J. C. et al (1990) *TAT: psicodiagnóstico en pacientes heroinómanos. Actas luso-esp. Neurol. Psiquiatr. 18 (1),* pp. 1-6.

Cabal Bravo J. C. et al (1989) *Personalidad-Dependencia: orientaciones conceptuales. Rev. Esp. Drogodep., 14 (3),* pp. 161-166.

Calafat A. y Amengual M. (1991) *Depresión, depresividad y toxicomanía. Adicciones, vol. 3, nº 1*, pp. 75-100.

Calsyn D. A. Saxon A. J. (1990) *Personality disorder subtypes among cocaine and opioid addicts using the Millon Clinical Multiaxial Inventory*. *International Journal of the Addictions: 25 (9)*, pp. 1037-1049.

Carcas R. et al (1989) *Estudio de las características de personalidad o esquemas de conducta asociados al consumo de heroína. Rev. Esp. Drogodep.*, 14 (4), pp. 257-264.

Casanovas L. et al (1996) *Automedicación y consumo de drogas en estudiantes universitarios. ¿Existe alguna relación? Adicciones, vol 8, nº 4*, pp. 441-446.

Cervera Martinez G. (1991) *Trastornos psiquiátricos asociados al uso de sustancias psicoactivas.* Curso Máster de Prevención de Drogodependencias. Universidad de Valencia.

Cervera G. et al (1998) *Variables relacionadas con la conducta de riesgo para la transmisión del VIH en pacientes drogodependientes. Actas Luso-Esp- Neurol. Psiquiatr. 26 (3)*, pp. 155-164.

Charney D. Nessler I. Bunney B. (1999) *Neurobiology of mental illness Part, IV.* Substance Abuse Disorders. Oxford University Press.

Craig R. J. (1984) *A comparison of MMPI profiles of heroin addicts based on multiple methods of classification. Journal of Personality Assessment, 48 (2),* p. 115-120.

Craig R. J. Olson R. Shalton G. (1989) *Differences in organisation of psychological needs between inpatient and outpatient opiate addicts. Journal of Clinical Psychology: 45 (3)*, pp. 462-466.

Darke S. (1994) *Benzodiacepine use among injecting drug users: problems and implications. Addictions 89,* pp. 379-382.

De Leon G. (1989) *Psychopathology and substance abuse: What is being learned from research in therapeutic communities. J. of Psychoactive Drugs. Vol. 21 (2),* pp. 177-188.

De Milio L. (1989) *Psychiatric syndromes in adolescent substance abusers. Am. J. Psychiatry, 146 (9),* pp. 1212-1214.

Donovan et al (1998) *Four addictions, the MMPI and discriminant function analysis. J. Addictive Diseases. 17 (2),* pp. 41-55.

Duran Gervilla A. (1989) *La intervención psicológica en drogodependencias desde el modelo psicosocial. Rev. Esp. Drogodep., 14 (3)*, pp. 189-196.

Duthie R. B. (1980) *Factor analytic study of the personality of female methadone outpatients. The International Journal of the Addictions: 15 (7)*, pp. 1091-1096.

Duthie R. B. Borrero-Hernández A. (1979) *Differentiating methadone outpatients from psychiatric outpatients and normals with the Mini-Mult. Journal of Clinical Psychology: 35 (2)*, pp. 457-459.

Edinger JD. Kendall PH C. Hooke J. F. Bogan J. B. (1976) *The predictive efficacy of the MMPI short forms. Journal of Personality Assessment: 40 (3)*, pp. 259-265.

Eshbaugh D. M. Karl D. (1982) *Typological analysis of MMPI personality pattern of drug dependent females. J. Person. Assess., 46 (5)*, pp. 564-572.

Ettorre E. (1996) *¿Cuáles pueden ser las dependencias de la mujer? El consumo de sustancias y la salud de la mujer.* En WILKILSON y KITZINGER *" Mujer y salud. Una perspectiva feminista*". Cap.6. pp. 96-114. De. Paidos, Barcelona.

Etxegoien R. et al (1996) *Los usuarios del programa de mantenimiento con metadona: perfil socio - demográfico y perfil de personalidad. En XXIII Jornadas Nacionales de Socidrogalcohol. Libro de Actas*, pp. 515-519. Ed. Socidrogalcohol. Oviedo.

Facy F. et al (1987) *Estudio comparativo entre una muestra de pacientes toxicómanos, un grupo de suicidas y un grupo de control de adolescentes a través del Mini-Mult. Revista Española de Drogodependencias: 12 (2)*, pp. 89-115.

Fernandez Gomez C. (1996) *Características de personalidad de heroinómanos tratados en una comunidad terapéutica. Adicciones. vol 8 nº 1*. pp. 33-51.

Fernandez Gomez C. et al (1996) *Evaluación cognitivo conductual de heroinómanos en comunidad terapéutica. Adicciones, vol. 8, nº 2*, pp. 161-175.

Fuertes Rocañin J. C. y Cabrera Forneiro J. (1996) *Locura o normalidad: ¿Una frontera fácil de traspasar? Ed. Confederación española de agrupaciones de familiares y enfermos mentales,* 1996.

Gaines L. Abrams Toel P. Y Miller L. M. (1974) *Comparison of the MMPI and the Mini-Mult with alcoholics. Journal of Consulting and Clinical Psychology. Volo 42, No.4* pp. 619 -723.

Gilbert J. G. Lombardi D. N. (1967) *Personality characteristics of young male narcotic addicts. Journal of Consulting Psychology, Vol 31.* pp. 536-538.

Gomez J. (2000) *El alcoholismo femenino: una aproximación cualitativa. Rev. Esp. Drogodep. 25 (4)*, pp. 424-451.

Gonzalez de Chavez (1992) *Mujer, cultura, identidad y salud mental (I y II). Rev. Asoc. Esp. Neuropsiq. Vol XII, nº 40 y 41.* 9-29 y 104-114.

Grant B. (1995) *Comorbidity between DSM IV drug use disorders and major depression: results of a national survey of adults. J. Subst. Abuse. 7 (4)*, pp. 481-497.

Haertzen C. A. Hill H. E. (1959) *Effects of morphine and phenobarbital on differential MMPI profiles. J. Of Clinical Psychology, Vol 15,* pp. 434-437.

Hagan T. A. et al (1994) *Inpediments to comprehensive treatment models for sustance-dependent women: treatment and research questions. Journal of Psychoactive Drugs, vol. 26 (2),* pp. 163-171.

Hammersley R. Lavelle T. A. Forsyth A. (1995) *Consumo de drogas en adolescentes, salud y personalidad. RET. Revista de Toxicomanías. 4,* pp. 11-19.

Hasin D. Grant B. (1987) *Psychiatric diagnosis of patients with substance abuse problems.* A comparison of two procedures, DIS and SADS-L." *J. Psychiat. Res. 21*, pp. 7-22.

Haviland M. et al (1994) *Alexithymia in women and men hospitalised for psychoactive substance dependence. Comprehensive Psychiatry, 35,* pp. 124-128.

Hurt S. W. Calrkin J. F. Morey L. C. (1990) *Examination of stability of the MMPI personality disorders scales. Journal of Personality Assessment: 54 (1-2)*, pp. 16-23.

Huseman C. A. et al (1990) *La bulimia como una forma de autoadicción. Tratamiento con clorhidrato de naltrexona: un estudio piloto. Clinical Trials Journal nº 27*, pp. 77-83. 1990.

Kandel D. B. (1980) *Drug and drinking behavior among youth. Annual Review of Sociology, vol. 6*, pp. 235-285. 1980.

Katzman M. A. Greenberg A. Marcus Y. (1991) *Bulimia in opiate addicted women: developmental cousin and relapse factor. Journal of substance abuse treatment No. 8,* pp. 107-112.

Kell M. J. (1995) *Opiate dependence, comorbidity and seasonality of birth. Addict. Dis. 14 (83)*, pp. 19-34.

Kendler K. Prescott C. (1998) *Cocaine use, abuse and dependence in a population-based sample of female twins. British Journal of Psychiatry. 173,* pp. 345-350.

Kincannon J. C. (1968) *Prediction of the standard MMPI scale scores from 71 items: the Mini-Mult. Journal Consulting Clinical Psychology: (32)*, pp. 319-325.

Kozlov A. A. y Rokhlina M. L. (2000) *Addictive personality. Zh. Nevrol. Psikhiatr. Im. SS Korsakova. 100 (7)*. pp. 23-27. 2000.

Kubicka L. et al. (1993) *The substance specificity of psychosocial correlates of alcohol tobacco, coffee and drug abuse by Czech women .Addictión. 88 (6).* pp. 813-820.

Labouvie E. W. (1987) *Relación de la personalidad con el consumo de alcohol y drogas en adolescentes: una perspectiva práctica. Pediatrician, 14 (1-2)*: 10-24.

Laqueille X. (1998) *Psychiatric complications in substance dependence. Soins Psychiatrics 94. 95*, pp. 21-24.

Lavelle T Hammersley R. Forsyth A. (1991) *Short scale for predicting drug misuse using selected items from the MMPI. British Journal of Addiction. 86 (1)*, pp. 49-55.

Leshner A. (1999) *Drug abuse and mental disorders: Comorbidity is reality. NIDA Notes. Vol 14, 4*, pp. 3-4.

Llopis J. J. Pérez B. De Vicente M. P. (1992) *Personalidad en mujeres alcohólicas y adictas a opiáceos. Un estudio comparativo. Anales de Psiquiatría: 8 (10)*, 398-404.

Llopis Llácer J. J. (1997) *Edad de inicio en el consumo de opiáceos y circunstancias concomitantes: un estudio con mujeres heroinómanas, su personalidad y evolución.* Tesis doctoral. Universidad de Valencia. 1997.

Llopis Llácer J. J. (1998) *Determinantes de la adicción a la heroína en la mujer: La codependencia. Libro de Ponencias de la XXV Jornadas Nacionales de Socidrogalcohol*, pp. 363-398. Ed Dupont Pharma. Madrid 1998.

Llopis Llácer J. J. Rebollida M. (2000) *Clínica de la mujer toxicómana. Un análisis de actitudes.* I simposium internacional : La adicción en la mujer. Fundación Spiral. Madrid 2000 (en prensa).

Magruder-Habib K. (1992) *Effects of drug misuse treatment on symptons of depression and suicide*. *Int. J. Addict. 27 (9),* pp. 1035-1065.

Marina P. A. et al (1996) *Los beneficios de la abstinencia. Un estudio de seguimiento de adictos a la heroína*. *Adiciones. vol. 8 nº 3.* pp. 295-309.

Martens J. (1999) *La mujer en la Comunidad Terapéutica. Rev. Proyecto. Nº 30.* pp. 11-14.

Martinez Higueras I. M. (1993) *Estudio sintomático de drogodependientes en tratamiento con el SCL-90. Psiquis 14 (4),* pp. 152-161.

Miller L. (1990) *Neuropsychodinamycs of alcoholism and addictions. Personality, psychopathology and cognitive style. Journal of Substance Abuse Treatment: 7 (1)*, pp. 31-49.

Miller L. J. (1997) *Treatment of addictive disorders in women.* En: Miller N.S. Gold M. Smith D. Ed. "*Manual of Therapeutics for Addictions"* Wiley- Liss, Inc. 1997 New York.

Mirim S. M. et al (1991) *Psychopathology in drugs abusers and their families. Compr Psychiat. 32 (1),* pp. 36-51.

Monras I Arnau M. Salamero I Baro M. (1987) *Perfil de personalidad y adherencia a grupos Comunicación a las XV Jornadas Nacionales de Socidrogalcohol.* Zaragoza. Diciembre.

Moon D. et al (1999) *Ethnic and gender differences and similarities in adolescent drug use and refusal of drug offers. Substance Use and Misuse. 34 88).* Pp. 1059-1083.

Morales E. Camarena F. Llopis J. J. (1992) *Evolución del alcoholismo en la mujer. Adicciones, 4 (1)*,pp. 33-44.

Mueser et al (1990) *Prevalence of substance abuse in schizophrenia: Demographic and clinical correlates. Schizophrenia Bulletin, vol. 16, nº 1,* pp. 31-56.

Nace E. P. et al. (1991) *Comorbilidad en el eje II en personas que abusan de sustancias. Am. J. Psychiat., 148*, pp. 118-120.

Navarro J. (2000) *El consumo de alcohol y otras drogas en el colectivo femenino.* EDIS - Instituto de la Mujer, Madrid. 2000.

Nesse R. M. Berridge K. C. (1997) *Psychoactive drug use in evolutionary perspective. Science. Vol 278.* pp. 63-66.

Newcomb C. et al. (1986) *Acontecimientos vitales y consumo de drogas entre adolescentes: efectos mediadores de la pérdida de control percibida y la falta de significado de la vida. J. Person. Soc. Psychol., 51 (3)*, pp. 564-577.

NIDA (2001) *Metodos de tratamiento para la mujer.* NIDA Infofax. 12964. Enero 2001.

NIDA (1994) *Women and drug abuse.* Department of Health and Human Services. Public Health Service. National Institute on Drug Abuse NIH publication, No. 94-3732.

Nogueras Ormazabal et al (1993) *El doble diagnóstico esquizofrenia y toxicomanía: revisión de la literatura. Psiquis 14 (3),* pp. 119-127.

Novins E. et al (1996) *Substance abuse treatment of American Indian adolescents: comorbid symptomatology, gender differences and treatment patterns. J. Am. Acad. Child Adolesc. Psychiatry. 35 (12)* pp. 1593-1601.

Ochoa E. (1999) *Trastornos de ansiedad y dependencia a opiáceos. Monografías de Psiquiatria. vol XI, nº4.* pp. 17-21.

Ordoñez Fernandez et al (1993) *Evaluación de la personalidad de los drogodependientes*. *An. Psquiatria vol. 9 nº 6*, pp. 256-260.

Oughourlian J. M. (1977) *La persona del toxicómano.* Ed. Herder. Barcelona.

Parker G. Wilhelm Kay (1995) *Influencias artificiosas sobre la diferencia de los sexos en la depresión. International Psychiatry today, nº 1, vol. 5.* pp. 2-8.

Pérez Galvez B. S. De Vicente Manzanaro M. P. (1994) *Personalidad alcohólica: modificaciones en relación a la abstinencia. XXI Jornadas Nacionales Socidrogalcohol. Libro de Ponencias y comunicaciones*, pp. 419-429. Ed. Socidrogalcohol. Bilbao.

Petry N. M. y Bickel W. K. (2000) *Gender Differences in hostility of opioid-dependent outpatients: role in early treatment termination. Drug Alcohol Depend. 1;58 (1-2),* pp. 27-33.

Pons J. Berjano E. (1997) *Personalidad y tendencias patológicas en mujeres toxicómanas. Psiquis 18, (8)*. pp. 311-316.

Pulkinen L. Pitkanent. A. (1994) *Prospective study of the precursors to problem drinking in young adulthood. Journal of Studies on alcohol. 55.* pp. 578-587.

Ramirez I Vila M. et al. (1990) *Relación entre rasgos psicopatológicos, rendimientos neuripsicológicos y tiempo de abstinencia en pacientes alcohólicos. Libro de actas XVI Jornadas Nacionales de Socidrogalcohol. Tomo III*: 829-833. Valladolid.

Raskin V. D. Miller N. S.(1993) *The epidemiology of the comorbidity of psychiatric and addictive disorders, a critical review. Journal of Addictive Diseases*. 12. pp. 45-57.

Regier D. A. et al (1990) *Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area (ECA) study. JAMA 264.* pp. 2511-8.

Rose R.J. (1998) *A development behaviour-genetic perspective on alcoholism risk. Alcohol Health and Research World Vol 22, 2.* pp. 131-143.

Rousanville B. J. (1989) *Clinical assessment of drug abusers.* En Kleber, H.D. ed.: *"Treatment of non-alcoholic substance abuse disorders. A task force report of the American Psychiatric Association."* APA. Press. Washington.

Runeson B. (1990) *Psychoactive substance use disorder in youth suicide. Alcohol and alcoholism 25 (5)* pp. 561-568.

San Narciso G. et al. (1998) *Evolución de los trastornos de personalidad evaluados mediante el PDI en una muestra de pacientes heroinómanos en tratamiento con naltrexona. Adicciones. Vol 1,* pp. 7-21.

Sanchez Carbonell J. Cami J. y Brigos B. (1988) *Follow-up of heroin addicts in Spain. EMETYST Project: results 1 year after treatment admission. British Journal of Addiction*. 83. pp. 1439-1448.

Sanchez Hervás E. Berjano E. (1996) *Características de personalidad en sujetos drogodependientes Psicothema, 8 (3)*. 457-486. 1996.

Seiden A. M. (1989) *Psychological issues affecting women throughout the life cycle. Psychiat. Clin. North Am. 12 (1)*, pp. 1-24.

Shaffer J. W. et al. (1988) *MMPI-168 profiles of male narcotic addicts by ethnic group and city. J. Clin. Psychol., 44 (2)*, pp. 292-298.

Shufman E. N. et al (1994) *La eficacia de la naltrexona para prevenir la readicción a la heroína después de la desintoxicación. Biological Psychiatry. 35. pp. 935-945*.

Sirvent Ruiz C. (1995) *Sobre la teoría general de la terapéutica e integración social en drogodependencias.* En Mateos Agut, M.,(Ed.) *Los equipos interdisciplinares en drogodependencias: estructura, estrategias y evaluación*, pp. 61-77. Burgos.

Sirvent Ruiz C. (2000) *Dependencias relacionales. Codependencia, bidependencia y adicción afectiva.* Ponencia al Ier Symposium Nacional sobre Adicción en la Mujer. F. Spiral. Madrid Octubre 2000.

Skuja A. Battenberg B. Wood D. Bucky S. (1980) *The impact of paraprofessional alcoholism counsellor training. The International Journal of the Addictions. 15 (6),* pp. 931-938.

Smith E. North CS. Spitznagev E. (1993) *Alcohol, drugs and psychiatric comorbidity among homeless women. An epidemiological study. J. Clin. Psychiatry. 54*, pp. 82-87.

Smith J. Hucker S. (1994) *Schizophrenia and substance abuse. British Journal of Psychiatry 165*, pp. 13-21.

Snyder D. K. et al. (1985) *Comparison of external correlates of MMPI substance abuse scales across sex and race. J. Cons. Clin. Psychol., 53 (4)*, pp. 520-525.

Soler Insa P. A. Grau M. (1988) *Trastornos Depresivos y dependencia de los opiáceos. Rev. Psiquiat. Fac. Med. Barna., 15 (4)*, pp. 195-201.

Stocco P. Llopis J . J. De Fazio L. Calafat A. Mendes F. (2000) *Women and drug abuse in Europe: gender identity.* Ed. IREFREA and European Commission. Venice 2000.

Stowell R. (1991) *Dual diagnosis issues.- Psychiatr. Ann. 21*, pp. 98-104. 1991.

Strain E. C. Brooner R. K. Bigelow G. E. (1991) *Clustering of multiple substance abuse and psychiatric diagnoses in opiate addicts. Drug and Alcohol Dependence: 27 (2)*, pp. 127-134

Strain E. C. Stitzer M. L. Bigelow G. (1991) *Early treatment. Time course of depressive symptoms in opiate addicts. The Journal of Nervous and Mental Disease, 17 (4)* pp. 215-221.

Stucker P. B. Moan R. (1979) Cit. En BURT M.R. et al (1979) *Psychological characteristics of drug abusing women.* NIDA Research Monograph Series. Public Health Services. USA.

Stucker P. B. et al (1974) *MMPI indices of personality change following short and long term hospitalisation of heroin addicts. Psychological Reports. 34*, pp. 495-500.

Stucker P. et al (1979) *Alcoholics and opiates addicts. Comparison of personality characteristics. J. Stud. Alcohol., 40,* pp. 635-644.

Svanum S. McAdoo G. (1991) *Parental alcoholism: An examination of male and female alcoholics in treatmen. J. Stud. Alcohol., 52 (2)*, pp. 127-132.

Swan N. (1997) *Gender affects relationships between drug abuse and psychiatric disorders.* NIDA Notes July/August 1997

Swift W. Copeland J. Hall W. (1996) *Characteristics of women with alcohol and other drug problems: findings of an Australian national survey. Addiction.91 (8)* .pp. 1141-1150.

Swift W. Williams G. Neill O. Grenyer B. (1990) *Prevalence of minor psychopathology in opioid users seeking treatment. British Journal of Addiction: 85 (5)*, pp. 629-634.

Szerman N. Delgado F. (1994) *Diagnóstico dual, medicación y objetos transicionales en el abordaje psicoterapéutico de las drogodependencias. Adicciónes, vol. 6, nº 1,* pp. 5-14.

Torres M. A. (1995) *Evolución de un grupo de pacientes alcohólicos a lo largo de los últimos cinco años (estudio provisional.).* En MATEOS AGUT et al. Ed. *"Los Equipos interdisciplinares en drogodependencias: estructura, estrategias y evaluación*." pp. 219-242. Burgos 1995.

Torres M. A. et al (1996) *Rasgos de personalidad en drogodependientes. Revista Española de Psiquiatría forense, Psicología forense y Criminología, 0, agosto 1996*, pp. 7-15.

Torres M. A. (1999) *Depresión y dependencia a opiáceos. Monografías de Psiquiatría. vol XI, nº4,* pp. 22- 29.

Torres M. A. et al (1997) *Variación de los rasgos de personalidad en drogodependientes y alcohólicos. Socidrogalcohol. Libro de actas XXIV Jornadas Nacionales Alicante.* Generalitat Valenciana, pp 285-313.

Tsuang M. et al. (1998) *Co-occurrence of abuse of different drugs in men. Archives of General Psychiatry 55.* pp. 967-972.

Van der Bree M. et al. (1998) *Genetic and environmental influences on drug use and abuse/dependence in male and female twins. Drug and Alcohol Dependence. 52 (3)*, pp. 231-241.

Van Etten M. L. Anthony J. C. (1999) *Comparative epidemiology of initial drug opportunities and transitions to first use: marijuana, cocaine, hallucinogens and heroin. Drug and Alcohol Dependence,* 54, pp. 117-125.

Vanyukov M. Tarter R. (2000) *Genetic studies of substance abuse. Drug and Alcohol Dependence, 59 (2000)*, pp. 101-123.

Varma S. L. Sharma I. (1993) *Psychiatric morbidity in the first-degree relatives of schizophrenic patients. Br. J. Psychiatry*, 162, pp. 672-678.

Walfish S. et al. (1990) *MMPI profiles of cocaine addicted individuals in residential treatment, implications for practical treatment planning. J. Sub. Abuse Treat., 7 (3),* pp. 151-154.

Walfish S. Massey R. Krone A. (1990) *MMPI profiles of adolescent substance abusers in treatment. Adolescence: 25 (99)*, pp. 567-572.

Walfish S. Massey R. Krone A. (1990) *Anxiety and anger among abusers of different substances. Drug and Alcohol Dependence: 25 (3)*, pp. 253-256.

Web L. J. Allen R. (1979) *Sex Differences in Mental Health. The Journal of Psychology: (101)*, pp. 89-96.

Weiss R. Mirin S. Griffin M. (1992) *Methodological considerations in the diagnosis of coexisting psychiatric disorders in substance abusers. British Journal of Addiction No. 87*, pp. 179-187.

Weiss R. Griffin M. Mirin S. (1992) *Drug abuse as self-medication for depression: an empirical study. American Journal of Drug and Alcohol Abuse. No. 18*, pp. 121-129.

Williams S. G. & Baron J. (1982) *Effects of short-term intensive hospital milieu therapy and youthful drug abusers I: Preliminary M.M.P.I. data. Psychol. Reports: 50*, pp. 77-82.

Zickler P. (2000) *Gender differences in prevalence of drug abuse traced to opportunities to use. NIDA Notes. Vol. 15, n. 4*, pp. 6-7.

7. THE COUPLE BEYOND THE CONSUMPTION

By Madalena de Carvalho Lourenço, Margarida Rangel Henriques

Writing about drug addiction, under a woman point of view, makes us think about some of the most crucial human systems. The couple is one of them, despite the amazing worldwide absence of bibliography on this issue. In other worlds, the lack of studies related to *substance abuse and couple* is impressive.

However, we all know how strong the bounds between Couple and Mental Health Care are. If the human couple is a source of resilience it is also a source of maintenance of malfunctioning and diverse symptomatology. To understand how the individual symptomatology can be part of the circular game of the multiple complex and permanent interactions of the married couple is a very interesting challenge. We know that behaviour (problematic or not) is only understandable in the surrounding situation and where the conjugality plays a relevant role. Without forgetting the individual vulnerabilities (physical and psychological), the nature of the conjugal system must be evaluated in order to understand the function of the symptom / pathology, namely drug abuse.

Within this context IREFREA has given some interesting contribution, especially with the development of the project "New approaches of prevention and intervention for drug – addicted women in Europe". In the *rapport synthesis*, regarding the study undertaken in 1998, the authors write:

"Regarding the partner, in all the countries there was a very high frequency of drug addicted partner. Very often the initial experiences with heavy drugs occurred together with the partner who therefore seems to play a key role in the history of abuse of the women interviewed. Often they do not tend to give their partner the blame, even, if, frequently, they say they used the drugs as a means of identification with this person, or due to the wish of sharing a world from which they felt excluded, or due to anger, impulse or self-destruction, all in reaction to the behaviour and history of the addiction of their partner. This data is found with surprising homogeneity in the different samples. The women often tell of experiences of physical, psychological ill treatment, and also of exploitation, when it was necessary to procure for the drug urgently. Frequently they were beaten, subdued or blackmailed psychologically by their partner, confirming also a repetition of dysfunctional relation models which lasted in time" (IREFREA, 1999).

We remind you that these conclusions come from the analysis of the answers from 340 women, from five European countries: France, Germany, Italy, Portugal and Spain.

Still regarding ill treatment, the marital violence upon women is maybe the variable which has been given more attention by the few researches who are interested by the issue *Substance Abuse and Couple*.

Many people agree that abuser partners are frequently substance consumers (alcohol or other drugs). The pathological jealousy is frequent and often manifested in the attempt to socially isolate the woman. The abuser does not allow the woman to work outside the house or to be involved in other outside activities (Rosenbaume and O'Leary, 1996).

The project IREFREA 1999 wanted to continue the preceding work on gender identity, from a qualitative point of view. The team organized Focus Groups with undergoing treatment and those who were not, in five countries: Austria, Germany, Italy, Portugal and Spain. As regards the variable "*couple*", the basic ideas were confirmed. Just as an example, we present some of the interviewed women's words, which highlight the paradoxality that involves the couples with a drug-addicted symptomatology.

"It was hard to let it go because my husband was a greater consumer too, and I'm with him for 19 years (…) my husband continues on consumption"; "I always had a very positive support from my family and from my husband. He still is a consumer, but he was the first one to encourage me to do this treatment"; "(…) he says that the drugs are stronger than him"; "(…) he died poisoned with a bad drug that they sold him"; "My companion has been helping me a lot. Even in the relapses, he always goes there to get me back. He went so many times to get me that he ended by staying there".

But it is not enough to evaluate. It is necessary to intervene. However, the association between drug addiction and couple therapy is problematic. The story we are going to tell you is about a meeting with a couple, within the context of couple therapy, which both of them felt as necessary, when they had finished their process of individual therapy. After the "I" it was necessary to take care of the "We" or maybe they felt that only by taking care of the "We" they would conclude the changes of the "I".

Manel and Manuela – A case of couple therapy[1]

When we meet Manuela and Manuel we seem to be facing two sides of the same coin. Manuela, extremely thin, looking older than her age and with a fragile appearance, contrasts with the robust look of Manuel, a lot older and stronger. Manuela is tense and shy. In her own words: odd, rational and mechanic. She surprises us with disharmonious and bizarre movements of the hands while she speaks. Manuel, sweating the whole time, is restless, affectuous, emotional and reacts to the slightest sign. Manuela, keeping

[1] The following text is a reviewed version of a text previously published in Portuguese, with the title *Manel and Manuela or a Therapy of Ex-Single People (*Lourenço, M. C.; Henriques, M. (2000). *Manel e Manuela ou uma terapia de ex-solteiros, in* A. P. Relvas – "Por Detrás do Espelho. Da teoria à terapia com a família". Coimbra, Quarteto).

an enigmatic appearance and an evasive look, presents a clearer, more objective and well-elaborated speech than Manuel's, whose speech is vague and confuse.

We are with the Paredes. One at each side, putting us on the other side of the mirror, as mere spectators, they develop parallel monologues, hard to criss-cross, in a deafness that brings us the fantasy: "Ai! Se as paredes ouvissem"[2]

Manuela and Manel have a common concern: to be a family and behave as a "normal" couple raising their three-year-old son, Francisco. This was their project of life, which made them take the decision two years ago to enter the heroin detoxification treatment of heroin, to which they had been addicted for a long time. So they left, each one to a different therapeutic community in order to work on their reencounter. A year ago they went back to their marital life and Manel claims that "things are not right, we have been married for seven, eight years and now without drugs is a bit complicated".

They told us little about each one's history and we renounce the exploration, taking the risk of competing with the "kms" of therapy they underwent.

We only know that Manuela is in her thirties, she has got a bachelorship that only gives her the minimum conditions to be a high school teacher. In fact, her job situation is fragile, and she never has guarantees that she will get a job as a teacher. Nowadays she teaches in a school where she used to work several years ago, in the town where she lived when she was a child, experiencing a return to her origins after long and troubled times in the city.

Manuel is half a dozen years older than his wife and he is now working at a stone-pit.

They met about eight years ago and they were involved in a passion that made them forget about everything else, they spent hours talking and communicating easily with just a few signs.

For a long time they were known to "live" tacked on to each other. They lived together for some time and then they got married, both of them had had other relationships and Manel has got a teenager daughter. Both of them used heroin, they did not have a permanent residence and they spent long periods of time apart, due to the circumstances. When their son was born they were not together and they started living together only when Francisco was two and just for a few months. Recently they have moved in, for the first time, to their own home with what we call "normal conditions" of a family.

Manuela moved in first and she started organizing the family life by herself, with Francisco. A few months later, when Manel moved in things became very hard. They argue all the time on small domestic issues and they have a bad relationship in general.

Initially Manuela took care of all the housework, while Manel was "stretched out", used to be served by his wife after a tiring day of work. Their situation became progressively unbearable to Manuela, who would be in a bad mood, would loose control, screamed with her son and hit the dog, which upset her a lot, so much that she

[2] N.T. -This refers to a Portuguese saying: "if the walls (paredes) could hear" and Paredes is also a common Portuguese surname.

started taking anti-depressive pills. She felt tired, exhausted and she could not accept what she was seeing. Manel's presence "is like an obstacle on the way, for he occupies a lot of room." His slow rhythm impresses her. She decided to make a "revolution", becoming very hard on her husband. She started demanding his collaboration in house chores and refusing to have sex as a kind of revenge, because she says she feels lonely about everything else and she goes to bed angry.

Another problem Manuela presents very insistently is Manel's drug use. She mentions that, when they moved in together again, they had the treatment rules of the therapeutic community that do not allow the consumption of any drugs; however, she has "caught" Manel smoking "joints" more than once. She considers this situation extremely difficult because of the risks she, herself, is exposed to, revealing serious fright of her husband, his instability, violence and the influence he has on her. Meanwhile, when he confronts her with the fact that his need to "consume" is sharpened by the hardship of their relationship, Manuela seems not to mind that the really needs to consume, suggesting a rather parodoxal wish concerning this issue. Recently she threatened Manel with separation if he took drugs again, for she is not willing to take the risk of being influenced to do it.

Manel considers that since he came home he has been very confused, because he has always dreamt of having a family and their own space but after having that "normal life" that he envied he is very anxious. He would like to be able to control that anxiety and to "talk about things" but for now, since the situation is very complicated, he drinks a few drinks and smokes a few "joints" to be distant. Nevertheless he has certain rules, for he thinks that they still like each other and he intends to have a life in common. He admits the mistakes his wife accuses him of, but he considers that a lot has changed at the same time, and he is facing a much different lifestyle, which is hard to handle.

Manuela does not find life as difficult as her husband, although she admits that there are a lot of changes and new feelings specifically involved in the experience of "being a mother and to feel the responsibility of a family life", which has been demanding a great effort. She adds that if she did not know that his son is very important to Manel, they would be separated now.

In the final summary of the first session, we explained the process to the couple, suggesting a second evaluation session with individual interviews, to get a conclusion about initiating the treatment guidance. We also explained that, in case we would proceed with a couple therapy, that would not necessarily determine whether they would be together or not, but it would facilitate the communication between them and their personal reflection about the situation. We also gave them back our perception on some central issues, suggesting that they should try to broaden their speech to the couple relationship and look for other aspects, besides drugs, capable of starting a process of seduction and sharing between them.

After the individual interviews, we had a meeting with both, announcing that we considered it possible to begin a therapeutic guidance, for which we propose a seven-session contract.

FOR A BEGINNING OF THERAPY

Due to several difficulties we felt in the communication with the couple and to their extensive "curriculum" of therapy, we put or bets on an intervention based on active techniques. These techniques facilitate the gathering of information and allow the expression of emotions, affection (positive and negative), life experiences and particular conflicts, and they stimulate the search for new transactional patterns (Andolfi, 1981). If theoretically we know that these techniques are pertinent, with the specificity of Manuela and Manel's marital situation we saw the indications for their choice broadened and we felt even more convinced of their effectiveness.

Verbal communication, both Manel's and Manuela's, soon made us fear to be trapped in that speech… circle, parodoxal, full of traps, with a fluent verbalization but very ollow, built on generalization and abstractness. When we tried to be directive we weren't respected, as if there was no reciprocal perturbation between them and us. What we were saying did not seem to make any sense to the couple, since we did not hear the echo of what we were saying, just monologues. Manel tried to escape to what we were asking, and Manuela answered in a mechanical way, without much elaboration. The speeches made sense, but the conversation made no sense at all.

We needed to silent them, so we could communicate! This was the most pressing feeling for both of us when we asked ourselves "and after all, where do we begin from?". We wanted to know them and know ourselves as a therapeutic system, but it could not be through words. We would, then, privileged the active techniques, the non-verbal analogical diversion. We put our bets on seeing them and hearing them, without listening to them.

To sum up: the personal need to shake those speeches was a fact! It was clear, then, the need to draw a path towards the therapeutic construction, since the manipulator power of each one of their speech could easily threaten the leading place of the therapist, making us feel too lost and unable of catalysing a thing in their communication. This lead us to think about the importance of valuing a hypothesis of war and of being consequential with it, without big inflexions.

As regards their relationship we felt they were closed in themselves, with big difficulty in dialoguing. They revealed urgency in making the relationship move on and build a "*We*" (Caillé, 1991), accessible to "trialogues". The first thing we thought was missing to that marital "*we*" was a body; so, having as horizon a "body and soul" dialogue, the aspect of the physical relationship would be the priority in the use of non-verbal active techniques.

Their attitude towards us sought to be very seductive. Manuela's by being polite to our requests and showing a certain intellectual exhibitionism. Manuel's by the spontaneity he would agree to other's speeches and the way he apologised alluring our tolerance. Facing the expectation of these seduction games and us being a couple of therapists of the same sex (situation of well-known technical vulnerability – José Gameiro, personal communication), we felt that the need to keep ourselves out of the "scene" protagonism

was reinforced, leaving the triangulation to the interaction between the two. Again it was important to define non-verbal active techniques, centred on movement and the physical relationship that would take them to get closer to each other and to focus their attention on that interaction.

This option, which lead us to that focus on the active interaction between the couple, would also correspond to the need to get away from the drug issue, massively mentioned by Manuela and Manel at the evaluation stage. In fact, to what concerns thematic incidence, we found in both speeches a permanent reference, direct or indirect, to the "consumptions" issue. To yield this redundancy would be like accepting them in this couple therapy as "ex-drug addicts", instead of challenging them to be ex-single people".

We had to decide what to do and to experience what?

Inspired by the recent history of both, by the request they presented and by what we had heard some time before from Sluzki and Cecchin (1996), we decided to work starting from the following metaphor:

Once upon a time there were two single people who met and were locked together in the same house. Then, everything became very confusing: they thought each other's habits were strange, they did not understand what to expect from each other … and the days went by in an agitation between blind and deaf. Something was missing and they desperately looked for it all over the house. Sometimes they looked more for the past, sometimes for the future, sometimes in themselves, sometimes in the other. Until they crossed each other's way and asked: have you seen "We"? Then they knew what they were looking for and they came for our help to become ex-single people.

This would be our story (not necessarily theirs); one of the possible, from their request and that would be used to change something … if nothing else, the request itself! In this case, the need of the story to anticipate a goal (the search for a "*we*"), would make the difference in the cases in which the therapeutic process defines itself, throughout the sessions. This time we chose to outline in each session the activities, according to what had happened in the previous encounter. We used as a metaphor the construction of buildings, where we all would be constructors of a certain project. It was our job to provide building moments between the both, and their job was to define the characteristics of that "we"… Everything was possible, as long as they would experience that *third member* in their relationship.

We started by outlining three big therapy phases: a first one centred on each other's discovery in the *here* and *now* through the metaphor; then a rediscovery of their "bodies" through touch and, finally the return to the word as the echo of what they had experienced. The process had to be cautious and gradual.

In the choice of activities we would bear in mind three complementary paths in the experiment: the form of expression, the subject in expression and the underlying messages. The first path would correspond to start by expressions through movement, then through touch an then through words (from each other and to each other). The second path would explore the individual authorship) then the dialogue and, finally, the *we* in each

other's words. As far as the path on the messages content, like we were "chemists" (who knows, maybe willing to be alchemists?) we wondered what could the *we* be made of. We concluded that we had to try it and decide what to add or not, along the way.

Now, looking back, we see that we started by trust, moved on to the power of non-verbal expression and get on to the possibility of letting the body feel and, next, we tried to decentralize and transcend the experience of one for the other. Finally, we tried to dialogue in a dance of verbal and non-verbal experiences of both.

And because the magic of dancing is the dance, we all "started the ball", with the most diverse songs … sometimes sad, sometimes happy; sometimes familiar, sometimes unknown; sometimes old, sometimes modern; but always, always exciting! We will, then, describe our dance, as far as possible, without stealing all the magic of dancing…

The Discovery Through Metaphor

This is high summer. Despite a long journey under a burning sun, the couple is in a good mood on their first session of the contract.

With the external prescription done in the previous session (search for what can be a source of sharing between both, except for drugs) we had wished to challenge and defy the couple, but also to evaluate their capacity of changing and adhesion to the therapeutic process. They mentioned that, despite not having talked about it, they started to go out on weekends, going to the beach… They say there were some changes around the house. Now the return has been, in Manuela's words, an "extraordinary pleasant thing and the husband no longer hinders in the sink. To her, what happened felt like something she had not felt for a long time. To Manuel things happened spontaneously, without much thought… Manuela replies that what happened took significant effort of both. They say that before the therapy they were together without being together… Now that does not happen.

We thought that was a far too fast change. Could they be scared and afraid of the real change? From what they had said about space, about the way people place themselves or not, we propose the "Sculpture of the Present" (Duhl and Duhl, 1979; Benoit *et col*., 1988; Prud' Homme, 1981; Caillé, 1991):

"you are going to imagine that you are sculptures and, in a first moment, each one of you is going to create an image that shows us how the relationships between you two are …how do you place yourselves towards the other. Than, each one of you is going to sculpture, tri-dimensionally, the statue you have mentally created."

Manel is very upset, explaining "it is a bit complicated to imagine both of us when that does not happen… There is always Francisco." After a long silence, while the couple does not face each other, Manel starts talking. We interrupt him, asking him to talk with his body. We want to start the active technique with him because he seems to be the less comfortable member with our proposal (Caillé, 1991).

Standing now, Manuel keeps on talking in a confusing way and he adds to his speech broad gestures: in the sequence of a lightning there is a circle that represents harmony, organization, especially in Manuela. But she is also a lightning because she explodes: with other people and herself. He, himself, is a bit of both: he explodes as well. He does not have the organizing ability but he is able to process "that circle". Despite the help we offer, Manel is incapable of overcome the words, "work the clay" and of using his and his wife's bodies to create a tri-dimensional image. We say that we will go back to his sculpture… We pass on to Manuela, who puts her husband taking a step forward and facing ahead. She touches him slightly on a finger of the left hand and stands a little bit forward. She says there is a connection she wants to reinforce, in the sense of moving forward, they walk towards goals; she is the propeller.

This explanation surprised us, because in this sculpture the physical contact point is insignificant. It is such a slight touch, almost nothing. We ask Manuela to imagine they were being filmed and that fifteen minutes would go by. Would anything happen? Manuela does not hesitate: she pulls her husband forward, who then is ahead of her.

We go back to Manel, who keeps saying he cannot do it. We try to simplify, suggesting that he should only define the position of both in a couple photograph. We help by asking questions: how is one body relatively to the other one? Where are you looking at? In position are your arms?

Manel is letting go… They are side by side both facing forward, Manuela's arms would not be still because she is never quiet. She looks like a "silly cockroach, moving her arms in the air." Her feet are moving too, one in front the other. With his own feet, Manel claims not to be able to do anything… He does not know how to put them. About the arms behind his back, he says that he tends to hide them. We take the "photograph" and we thank for the interesting living statues they have made.

When Manel played the role of the sculptor, Manuela did not quite understand what she was doing "there". She tells us that since she was a child she has never been keen on physical contacts, she took a long time to let someone touch her, but for a photograph she makes an effort and she is sorry that, when her husband defined the positions for the portrait, there was no physical contact.

To Manel it was hard to imagine and sculpt. He felt good being sculpted, Manuela "did it right", but he was not able to be so original as she was. The push his wife gave him represents their behaviour for some time now, but it was not pleasant, for he would like to be ahead, or to push at the same time as his wife.

Manuela does not avoid adding that she tries, that she exceeds herself, especially when she realizes that it brings benefits to them all and that she would like him to have made the sculpture. Manel's words:" I know. I've apologised... I know apologies don't do much". This speech was a step back to our first session, when Manel shows a position of dependency and childishness towards Manuela.

After the break, we conclude the session saying that it was rather illustrative and that it spoke for itself. Keeping a very experiencing register, we make a challenging silence.

We do not wish to reinforce the couple's incompetence, but we do not want to hide it. We think that the progress reported were actual changes to the non-changes. Or were they stimuli to continue the therapy? Or the will to believe that the therapeutic process is being positive? To sum up, we mention that it was a very tense situation to us all, remaining the idea that we are in the beginning of a long walk... and that there is a long way to go. We value the beginning of that walk and we thank them for the effort, for we are conscious that we haven't asked easy requests. Manel feels the need to, once again, apologise because he thinks he hasn't tried hard enough, but that is "very complicated". In fact, we also felt that the challenge of the discovery through metaphor, of oneself and the other, was a true adventure to both, but an adventure we would like to continue.

It is still summer. We only meet the Paredes after the so wished holidays, when the sun was warmer...For the second session we had a crucial goal: to understand and to show how each one sees the other and how he / she is seen by him/her, promoting the construction of the couple. In order to do so, the "book technique", in which you give body to ideas, seemed the most useful, namely for the clarity it can provide, an important aspect for the confused and paradoxal Paredes.

Manel reveals the habitual physiological signs of his anxiety. We present the task, clarifying that both of them had to do it, but while one was doing it, the other had to be an observer, without the possibility of interfering... and these roles would then be inverted. We ask Manuela to sit down outside the circle and we give Manel a set of books of different sizes and thickness, explaining that

Each book would first represent a quality and after that a fault of the consort.

In a task that at first seemed simple, the confusion generated by Manel was plenty. This book goes here... no, it's there. This is a quality...no, it is a fault, after all. Finally there is a pile of books and the hierarchy is defined... ah!... there is one more book to add.

Here is the result achieved, from the best to the worst quality:

1st mother; 2nd organisation; 3rd demand as a mother; 4th affection as a mother; 5th responsibility as a mother; 6th difficult personality, too much perfect; 7th partner ("excellent coordinator of space and time"); 8th tolerance.

As regards faults: 1st intolerance; 2nd annoying; 3rd frigidity ("connected to the three big qualities").

Now it is time to Manuela portray her husband. She performs the task with more confidence and faster. When we look at the final hierarchy we see, from the most important to the least important quality:

1st affectionate (exaggerate in bed); 2nd childishness (that is, know how to play); 3rd determination (perseverance in his job); 4th support; 5th passivity and calm (that is also an affront).

A first hierarchy of the husband's faults is the following: 1st rage, anger, fury; 2nd irresponsibility; 3rd egocentrism; 4th "Manel-peacock"; 5th dramatization.

Yet before we finish, Manuela adds that, between the husband's first and second faults, there is another one: he cannot accept "no" when it comes to sex, revealing the

hardship in "respecting" her in that area. Manel says that, in fact, he is egocentric, but it is not intentional and he cannot mend it. He is affectionate, but he has been "affectionately needy" since he was a child.

When we come back from the break, we sum up what we have seen, comparing the four piles of books. In Manel's distribution the pile of qualities is bigger (there are more books) than the faults one. Basically, he sees Manuela as a mother (in fact, in that role she is perfect...), then as a person and in the end as a wife. The result of Manuela's task is two similar piles, but again her husband's qualities are bigger than his faults. She sees Manel essentially as a person. The thing each shows more difficulty in seeing the other, and to see themselves, is as a partner. The big issue is to construct themselves as a couple. We choose to comment just on what we have seen when we looked at the books. The system discovered itself. That information is the one which makes more sense to it.

After the sessions, it seems essential to us to activate the interactions, in order to have Manel and Manuela touching each other, since both have mentioned a great difficulty in that area. We reinforce the idea that it is a matter of stimulating the analogical communication, through games, as a bridge to verbalization and, parallelly, to work the couple's trust, the fact of being capable to give themselves to each other more easily.

The Rediscovery Through Touch

Reminding and reproducing in space the "finger" sculpture Manuela has built in a previous session, when she "pulled" her husband towards a project, and when Manel felt that he would like to be pulling, we highlight that for the game of complementarity trust is necessary and we introduce a game we are going to call "Trough the Lenses of Trust",

In which one of you leads and the other has the eyes closed. The last one leans on the other who leads him/her as delicately and responsibly as possible, guiding his/her body in space. We say that it is necessary to pay attention to the rhythm of the one being lead and we suggest a way of holding to each other.

When Manel realises that he is the first one to have his eyes closed he exclaims "Oh Jesus!". Manuela proceeds with one hand on her husband's shoulder and the other one on his arm. She grabs him hard, even pushing him .She talks to him, but not much. Manel is tense, sometimes with his eyes half opened. We change the positions... Manel holds his wife with both hands on her shoulders, without unnecessary force. Manuela walks relaxed. The husband is giving some verbal indications.

Manel tells us that, at first, he had an instinctive fear, then he "let himself go", because he felt confident, "despite Manuela's hands being light, they are there, you can feel her presence". He especially liked when he heard his wife's voice, for he felt more secure.

Manuela also says that when she was being lead, her first steps were very scary, but then she "let herself go" and everything was simpler. In fact, it would have been good if they had extended that time. She thinks it was painful to lead the way, excusing herself with the physical effort she had to do and with not having been able to establish

a rhythm that she would have wanted to be faster. When she was told she would have to "lead" him she imagined that would imply a total control from her, where she would dictate the rules and she would lead in order to eliminate Manel's fears, him becoming a part of her. But she did not control everything. When they were reaching the end of her leading some ideas, on different ways of leading, started to come to her head and to extend that moment would have been good. She comes to the conclusion that it would have been better if she had lead the way more calmly. We comment on that, reinforcing the idea that in this game they do not take a passenger but a co-pilot. When there are two of us, we are not *one*, not even *one plus one*, but something different.

To Manel leading is not easy, but his wife is light and she facilitated his leading by participating and letting herself go. This Manuela's easy going has made him stop enjoying the game, after a while. On the contrary, he liked a lot the feeling of being lead and he would have liked to be in that position longer.

We suggest a new game: "Pulling which Face". The goal is to *While one of the members of the couple pulls a "doll face", the other explores and defines his/her facial expressions. Each can shape the other's face as they want.*

Manel is a little reticent on playing this game. He says he "is not very good with his hands". We tranquillise him and (re) arrange the sofas in such a way the couple are facing each other. The game starts...

Manel is the first one to mould. For him it is difficult and agonizing. He tries to mould, often saying that he "cannot do it". He puts Manuela with her eyes closed and a serious look. Then it is Manuela's turn to be the sculptor. She moulds delicately and sensitivitely, but Manel laughs a lot and undoes what she has done. Despite the nice atmosphere, where we orientate, incentive, play and laugh together, Manel is tense and contracted. Manuela puts her husband with "half a smile". He holds her wrists, asks her to stop and laughing inquires if she is done.

We ask Manuela to mould the face she would like her husband to pull when she goes to bed. Manel laughs and, with a joking look, tells her to put him asleep right away. She keeps moulding and he keeps undoing it. Finally, the "clay" has a light look, without an open smile, but with a pleasant and relaxed look. "Imagine that the alarm-clock goes off! Which face would you like Manel to have when he wakes up?" She moulds him with raised eyebrows and almost smiling. It is Manel's turn to sculpt his wife "at bed time". He does not hesitate. He makes her with a frowning face, with her eyes wide open, angry. He stops and, realising that it should be the face he would like her to have, he mentions that it would be quite different: half-serious, with a disguised smile. In fact, that is the same face he moulds for the wake-up time. Manel is not totally satisfied with his moulding: he would like her to be in "a better mood" both at bed and wake-up time.

Before the break, we gather the four sofas and we talk about the "wish-faces" that we saw and the "reality-faces" they have at home; the differences, the certainties and the fantasies.

In the second part of the session, we highlight the fact of them having been able to experience the diversity of roles, all of them important in different spaces and times. Manel tells us that he is a very anxious person, who gives up very easily, but he does not want to give up this therapy, which for him means he is feeling good.

Although this was not a painless session for the couple, it was very rewarding to every one. The link therapist- couple seemed to be strongly present... and Manel's sweating had diminished. We felt rewarded in our self-esteem of techniques and more confident in our therapeutic construction project. We were certain they would be back, despite the many kilometres they had to take to attend the meetings. And they came...

Once the importance of trust and body expressivity in relationships were addressed and still focused on the project of drawing a sketch of a "We" with two people who intend to become ex-single people, the time had come to dedicate ourselves to the physical relationship, in the broad sense of the word. The challenge would now be to find the other member through the body.

It was a matter of promoting body communication, providing each one of them the exploration of physical sensations of pleasure when touching each other, through activities centred on the sensorial experience. We prepare a sequence of situations that presume progressive physical involvement, implying elements we consider basic in the relationship: touch, move, giving pleasure and taking care of the body with the body.

We enter the room and we notice that Manuela is prettier, more feminine and attractive. We were excited ... that seemed a good start. We arrange the sofas, leaving the "scene" to the couple, whom we put face to face, while we become second plan. We would start by experimenting the focus on subtle epidemic sensations, through slight touches on a very restricted area of the body.

We present the game "Writing on the hand":

"You are going to play with the hands; one of you is going to draw capital letters on the other's hand, who has the eyes closed and is going to try to guess the letters, until he/she guesses the word. First you draw on the back of the hand and then on the palm and you can use both hands. Try to use simple and short words that refer to something the other person likes and draw the letters calmly, while the other identifies them aloud. When the letter is not recognized it should be repeated until it is correctly pronounced."

After the explanation of the game, Manel tells that they are angry at each other, and surprisingly he offers to start writing. Truly, this was the first time he came forward to the game, without trying to supplant it with reserve and verbal justifications, which made us wonder whether he was getting involved more easily in this dynamics of speaking with the body.

Manel, serious and silent, keeps on drawing letters, until Manuela says the word *sorry.* When Manuela discovers the word, Manel keeps his head down for a moment. They swap and Manuela takes a certain time thinking about the word, then Manel identifies *calm.*They swap successively, Manel writing *son needs,* then Manuela *sofa,*then him *tired,*and finally her *how?*

The comment on the game is about the sensorial dimension, specifically on the exploration of the tactile sensations experienced, for which we ask them on which part of the hand they had the most pleasant feeling. Manuela claims that she likes the sensation on the back of her hand better, although it was less perceptible, and to write on the palm of the hand. Manel makes the opposite choices, preferring "to be written" on the palm and to write on the back.

We underline the difference of sensitivities and the complementarity that those "opposites" assumed, allowing each one of them to follow their preference, to do whatever the other one liked to feel, in a kind of "fitting".

After a contained situation, of great concentration on a part of the body, we would pass to a moment of expansion, in which movement could loosen a little those two bodies, that seemed so tense. Touch could now travel through the whole body and it would privilege the playful and funny aspect of the interactions, associating touch to laughter, as a predecessor of pleasure.

We push the sofas back, leaving plenty of free space and we introduce the "Statue Game", in which

Each one on their turn holds the other one and makes him/her spin and, suddenly lets him/her go. The other member should stand in that position as a statue, while the former is going to try, without talking, make him/her laugh or move.

They start playing and the positions they end up in are basically the same: standing straight and with their arms down. They make each other laugh... Manuela by touching lightly with her finger tips on several parts of the body and Manel, first letting out a "hello!" and then by touching certain parts of the body. We hear the laughter coming out more easily.

Stimulated the body movement and the touch, now it was a matter of going a little more further: "to touch" the other's body and give him/her pleasure. That would demand from each of them to allow oneself to physically touch and be touched, as well as "deviate from oneself" in order to give to the other, a crucial issue in that relationship of individual speeches, where the movement of give and take seemed to have no place. We move on, then to the "Massaging Game", suggesting that

Each of them massages the other's back. One is standing leaning on the wall with the arms slightly folded and keeping the legs a little opened and firmly on the floor, while the other is massaging his/her back the way he/she feels like it. When they switch places, the one who is about to massage, first has to imitate the massage he/she was given and, then, he/she has to invent a new one that the first one will repeat.

So, we demand that both are focused on the physical sensations and on the movement of the action.

When we comment on the massages, Manuela declares that she has no pleasure massaging because she does not know if she is doing it right and that, when the movements became repetitive, she lost interest, for she thinks it needs calm, which she

does not have. Manel refers that every kind of physical contact gives him an immense and indescribable pleasure, because it is not frequent. He adds that he likes giving and getting pleasure a lot and that he tried to be careful, in order to give her pleasure without hurting her, for he claims that "I have an uncontrollable hand and I know how sensitive she is".

From the "writing on the Hand" to the "Massaging game", we activated an increase of the bodily involvement and of the intensity in the physical sensations that we aim to end up in the pleasure of relaxing in each other's hands. It was a matter, afterwards, of exploring other dimensions of giving: to give oneself to the other and to take care of the other. The game we chose was "the Puppet's Arm", in which

Each one, at a time, has a num arm which the other one will manipulate, putting it in whatever position he/she wants.

They start with Manuela sitting and her husband holding her arm by the elbows, making it spin, carefully. When they swap positions, Manuela raises her husband's arm to his head and lets it fall, until Manuel complains; then, she rotates his arm, apparently more gently, but she ends up dropping it again. After that, Manel raises her arm too and lets it fall once. When it is Manuela's turn again, she puts his finger up his nose, hard, she twists back his fingers and drops his arm again, but Manel holds it in the air and, then Manuela grabs his arm by the elbow and twists. By then we interrupt that "escalade" of aggressiveness and we announce a break.

In the final comment, we point out the importance of their investment on what they were doing and of them having been able to tell their fears, the tenderness, the anger, without words, although they were angry at each other. However, if it is essential to show our anger, when we are taking care of the other person is not the best time to do it. We add that it seems fundamental in the physical relationship, the identification and exploration of several pleasant zones, escaping from the myth that both should have pleasure in the same way and at the same time, valuing the ability of each one to feel and give, making the best of the differences.

Before we say goodbye, we prescribe the couple the invention of a new non-verbal communication game, preferably involving physical contact, to show us in the next session. Our goal with this suggestion was to facilitate the generalization of the "touch" dynamics in which they were involved, in their day-to-day environment.

The possibility of talking

Trying to be in each other's shoes

Excited with the development of the couple's non-verbal communication we planned another set of ludic situations now centred on "trying to walk on each other's shoes". This meant giving them analogical dialogues which made them go beyond their emotions and place themselves on the other's experiences, either in moments of pleasure or in moments of conflict. For the first time we enter the session without

questioning ourselves about their approval to the propositions we took. Meanwhile, we were in for a complete surprise!

We were immediately confronted with the angry and tense tone of voice of the couple, which seemed to follow the angry exchange of ideas that stood out from the "Puppet Game" played in the end of the previous session. In the end, what seemed to remain from that meeting was not the involvement, but the aggressiveness with which it had ended.

We began by evaluating the given task asking if they had invented together that non-verbal game, to which they both complain. Manel refers, in an angry and critical way that it had been talked about but that it had not been put in practise. Manuela, always trying to stand out by actively cooperating with therapy, makes a point of hinting that she invented it alone, but that she could not explore it because her husband's sensibility is not enough. She reinforces the idea in a vindictive tone and generalizes that "if there is no sensibility to deal with other things, then it is not worth it."

Suddenly, to us (and we believe to them) it is as if we were still in the beginning. The atmosphere was very tense and afterwards Manuel "explodes". He expresses discontentment and anger with the sessions, saying that he is tired of the hypocrisy of being there trying things that are not going to work. He considers games imply that people really want them to work and he mentions that there are moments during the sessions when things work out, one or two days later they are all right, but then it is "square one" again, which makes him think that they are not being honest with each other, showing some suspicion about his wife's intentions.

We ask them if they think that things that go wrong should be brought to the session. By then the couple expresses opposite views. Manuel says yes and Manuela, who does not want to discuss it, depreciates the advantage of this choice, adding that the uneasiness has always existed and that she rather not be talking about it there, because it did not fit what was trying to be done. The husband, annoyed, says that then he does not think it is important to be making an effort just for half an hour.

Confronted with the impossibility of a verbal dialogue about conflicts, with the circularity of complaints, and maybe with our own feelings, the mixture of discomfort, anger and deception we ended by presenting the work plane we had brought to the session, appealing to the importance of exploring alternatives of communication. We propose "The Mirror Game" where each one would try something like

walking on the other's shoes, following all his/her movements.

Manel insists that he does not feel up to participate, showing a feeling of injustice by the fact of making a daily effort to please and not being recognized, as well as having changed a lot, and that regarding both of them nothing had been tried yet. He announces that he is tired of the situation and that he is starting to question the option of marriage, and its benefits to their child. For he does everything to save the relationship because he loves Manuela and Francisco, but he is afraid of being the cause of disturbing

Francisco too much. Manuela does not react. We show understanding towards Manuel's feelings and we stress out the effort he is been showing.

We underline that we believe that what we are proposing might be useful to them, but they will have to decide if they are taking advantaged of it or not, an option which will be entirely respected.

We suggest a break for them to decide. This anticipated "break", in relation to the usual moment, was indispensable to see how they would deal with that situation which was becoming more and more tense and delicate. It was clear to both of us the couple's difficulties in experiencing conflicts: Manuela refusing to get involved and Manuel "curling up" in a speech full of real examples. We then considered fundamental to adjust the goals of the session to the way we deal with conflicts, turning on a first moment to an active strategy as a way of helping his expression and "leaving" Manel monologue - so we could then focus on a definitive episode lived at home.

We return and propose the experiment of the game "Word Fight" where

each one, in turns, has 45 seconds to say all the insults they want at the time including things they do not believe in. The other person cannot react.

Manel mentions that they have passed the insults phase and that silence is the biggest insult a person can get from another. Chairs are placed face to face, Manel changes chair and participates in silence in his insults turn. Manuela started the game calling her husband: a child, an egocentric, a coward, a liar, a baron, and a loser. Manuel, in his turn says absolutely nothing. We ask them to invert positions, each one saying what they think the other would say. Manuela, playing Manel, calls herself: "dry, cold, deceptive mother, rude, mean, tyrannical, bad loser; at the same time Manel, rubbing his face with his hands, mumbles: "That makes two of us". He then remains in silence.

Next, we suggest them to recall a recent conflict situation and that they bring a little of it to the session. Curiously, it is not Manel who chooses the situation, but Manuela, who refers to a situation from the Saturday before, when her husband wanted to smoke a "joint". Manel shows the despair he felt at the time, but none of them describes the event. When we ask them to do it, inverting roles, Manel interrupts, stands up, says we will not do anything else; "threatens" that he does not know how things will end and with a brief "excuse me", he leaves the room.

It was the first time this happened!… We were even more upset…Our expectation that Manel would end up participating, as it happened in the first session, had just "come out" frustrated. Later, that difference in his attitude "smelt" as a change… maybe Manel was breaking that cycle of trying hard, almost as an attribute, to later apologise successively, putting failure down to him. He allowed himself, now in a more frontal way, to say "no" and to ask for cooperation instead of excuses.

One of the therapists leaves the room to go and find Manel, in order to make "emends" about the situation and asks him if he does not want to say goodbye, while the other therapist and Manuela remain silent in the room. Manel returns, says that he is there only to say goodbye, justifying that the situation is too heavy for him and that

he has reached the point when he cannot stand it any longer. He also suggests it would be better for them if they "move on with their lives", start over again separately than to hurt each other more and take a step back.

We inform that, meanwhile, the session is over – which makes us feel an inevitable relief because of the difficulty we felt increasing in catalysing that conflict. When we schedule the next session, Manel stress that "no matter what happens someone will come". We say goodbye, adding that the goals are the same that were defined by the four of us at the beginning of the therapy and that we will be waiting for them.

At the end of the session, we were swinging between a speechless look paralysed by the absurd of the situation and an avalanche of questions and fantasies about what had just happened to all of us. It stood out that for the first time the question of divorce had been approached, as well as the urgency to explore explicitly the sexual dimension in the couple's relationship

Dialogues

After what we had lived and felt in our previous session, we had to stop… to really stop! With time and total availability to reflect upon everything that had happened until then. There was surely some requests to which we were not paying attention!… Were we deaf? At the supervision, then undertaken, we understood that Manel was angry at us. He had made appeals the whole time, desperately asking Manuela "come to bed". And she would not go. She was collecting with interests.

It seemed fundamental to give them space to communicate about their sexual life, without evasions, without half-words. We would give a little push so that, once more, the unprepared protagonists played their parts in a set with a save net.

The moment to change technique had come. This time we did not predict using any active technique. They would still be the main characters and we felt they were more capable of doing it in a digital register.

As always, the couple arrives at the scheduled time. We propose that each of them examines how he/she is and tells us how we can be of use.

Manuela says that it is hard for her to talk about it, because she is going through big changes that have to do with the couple, and especially with herself. But she keeps on talking: there has been a big change in the couple, for conflicts are milder and, if it is true that there is a deep lack of dialogue, when it exists they talk about more concrete and important issues than it happened before, especially in what concerns Francisco's upbringing. It is him that they have in common, "besides him, practically nothing at all".

It was clear to us Manel's implied message: she wants the separation and she does not say it. At the here and now of the session Manel deals with the matter. Maybe a few years ago he would not accept the hypothesis of a separation, now he accepts it. Things are easier; he is calmer and more capable to react to the separation. Besides, the balance is positive. A year ago, if he had been through what he has been through now he would

have probably gone back to "dust", he would not have endured it. Now he does not even think about that possibility… " It's time to move on". He goes on saying that the therapists have helped a lot, but at the moment, they depend more on themselves than on us. Only with us, in the sessions, had he heard and knew fundamental things… and that disturbed him, because he thought those were things that should have been discussed sooner, between the two.

Now it is Manuela that interrupts her husband: "he hears things as he wants". He has told her two or three times that things concerning the couple's relationship are really bad, namely to what refers to sexual intercourse… but immediately after he concludes that he is not the one who is going to take the necessary steps, she is the one who will have to take them. Looking at us, he points out that he hasn't talked about separation that has never crossed his mind as something that might happen immediately. At this moment, Manel turns to his wife and asks her if she thinks there is an alternative to separation. Manuela answers him that she is not God, so she cannot give an answer to his question. At this point of the interview, the atmosphere between the couple is very tense. The question of sexuality that once again had been abandoned along the way is recovered. Manel says he now knows how to deal with sexual abstinence… and that he even has a new room, his son's. The fact that Francisco is growing-up and he has never seen his parents caressing each other bothers him. Manuela says that her son had been sleeping along for six months (that was good news to us!) but, due to a cold, he went back to his parent's bed. Adding that, in fact, with Manel's "departure" she has more space in the bed, because he is always leaning on her and does not leave her any space.

To Manel the solution to their problems is no longer a sexual reconciliation. Past does not have to be collected all the time, every day, intentionally, in such a sarcastic way. Manuela confirms this accusation: if she talks to him about that it is because he complains and to make him see that "it used to be the other way around, she has been through it". She recognises that there are lots of moments when she does not know how to give her lap, and then a snowball begins: her husband asks for her lap and she does not give it because she is angry and the snowball grows.

We remind important moments of "lap" lived during the sessions and we ask Manuela if, not thinking about the most obvious forms of "laps", there are not other caresses, other physical intimacies that are less hard to do. She claims that touching has always been difficult to her and that Manel was the first person with whom this difficulty was easier, but now it is complicated. When she is feeling "down" because of other things that have nothing to do with the couple, she asks for her husband's lap. The last time she did it, she did not get it. With tearful eyes, she claims that what shocked her was not that particular time, but to realise that there is a set of moments so alike. Manel, touched, comes to the conclusion that they have achieved a lot this last year, "we were drug addicts, completely soaked in shit, in every way. We tried to be a family".

We propose the usual break, and after that we mention that there is an aspect of their conjugal relationship that makes it specific: sexual intercourse, the physical relationship in a broad sense. It seemed important to us to dismantle a permanent intellectualisation

about the body experiences, a certain need to justify to oneself and the other the reason for a determined response of the body, when it talks for itself. We point out that any of the two bodies has many moments of rejection and siege. What seems fundamental is to start giving space to those bodies that have marked so many experiences; without speeches, investing in short stories, in new physical experiences… very physical. It is important to be more tolerant to the body and to build more present references of physical gratification. There is the guarantee that those experiences will be interiorised as positive ones and will give more physical easiness to the relationship.

We make a prescription: until the next session they should explore variations of "Lap giving", but they cannot have sex. Manel, looking surprised and with an ironical smile, turns to his wife saying that it is fine by her… and by him too.

A month later, we have come to a special moment for us – the last session of a couple's contract that had demanded a lot from us – creativity, action, reflection. It made us crumble down prejudice (this "gender" will abandon therapy) and now, it made us fear that it was too soon for us to "be silent", without drying out the issues of sexuality and separation. It all remained open… we were facing the anxiety of not knowing the prophecy of its course, and remain expectant. All seems possible. Maybe there one knows the happiness of building up the walls that better fulfil us at each moment. How would the session run?! We entered the room…

The "external task" was respected. Manel says: "at great cost, but it was respected". He meant the lack of sexual intercourse. However, there were some "lap" moments.

We created two small piles of similar papers, one for Manuela and the other one to Manel. We approached the empty sofa, which symbolizes the couple's relationship. In turns, they will take from their own pile a paper, read it and complete aloud the already started (similar sentences singular – I – and plural – we). It was inevitable to ask them to answer twice in a row: once in their own name and the other time as an interpreter of the entity the relationship is. We point out that there are two papers on which is written the beginning of a single sentence. In that case it is up to each of them whether to create one or two statements. It will be a game of three (Caillé, 1991). We dramatize the situation: three sofas, one for each of them and a third one where they sit together when each of them speaks in the name of the relationship.

Lets see same of the sentences:

Manel

I have never told you but… *I feel like being on my own for some time.*

We have never said it but… *We think exactly the same: we both need to be on our own for some time.*

Manuela

I have never told you, but… *your degree of exigency towards me, in everything, makes me it very difficult for us to live together.*

We have never said it, but… *we are making some progress.*

Manuela

Today… *I believe more than yesterday.*

Manel

In the future… *I hope the mistakes made in the past will not happen again. Despite mistakes being important too.*

With a beautiful smile on his lips and his eyes shining, Manel says that the longer they stayed there, the more they would "argue". We observe that when they both sit on the "relationship sofa", they always do it the same way: sharing the space, almost without touching each other, suggesting that the rediscovery of touch is not interiorised yet.

When we come back from the break, we comment on how something that was always present during the whole process has become so clear at this last session game, which they turned into a "Cat and Mouse Game" – a dance where they are very successful in several areas of life, including the sexual one. One grabs the other turns and the first one is already leaving… But this game tires, wears out, raises difficulties. It is like running without leaving the same spot; it is a stop and go game. That is not indifferent to the ambivalence of each one's affection in the relationship: I like, I do not like; I want, I do not want. This does not have to be dramatic… It can be, nevertheless, a reality that is being managed more than solved, sometimes in a more comfortable way other times with more pain and trouble. What we felt in this session was the presence of a We, of a third that was even capable of complaining. In the first meetings apparently that did not happen. Is seems that there has been a significant evolution at that level.

Manel says that that *third* has always been there, asking for help. Manuela says the couple's existence nowadays is becoming more and more distant from that of the moment they came looking for us. "It is like discovering someone I never knew… It is like building everything from scratch". Of whom was Manuela talking? Herself? Of Manel? Of both?… Surely of them all. No one is indifferent. The growth of each of us was a movement of co-construction.

We ended then the established contract and they reveal today the difference from our first meeting. They were ready to leave. We say goodbye with an experience-increased look, and, hopeful, we lay all our trust on each other's constructive protagonism in managing their relationship.

Without Them

All that we have told you did not really exist. It is an intersection between our construction of the world and the construction the couple built in each of us. What each of us saw has mainly to do with herself. Sometimes we allowed the tree to hide the forest. We tried to cut it, but it were always our eyes and not the other's that watched that vastness, where we had a target that we called "We". Our goal was always to create an opening space in a wood where two people could find themselves again with something that had vanished: a symbolic third, mutually satisfying which allows Manuela and Manel not to

be strangers living under the same roof. The first requirement to fulfil a couple's therapy is the existence of a mutual request to improve the relationship, request that corresponds to a real wish of both the spouses (Santos, Alarcão e Cortesão, 1991). This real wish is rarely explicit, as we may confirm, but in this case it was there. If we do not have Cupid's arrows that inflame passion on humans, we have the duty to give an answer to a request of reducing suffering and uneasiness, always trying to work the present relationship. We moved on. We know that the tension on the couple's diade is dissipated if the couple keeps in touch with a third person, who stays neutral and objective (Nichols and Schwartz, 1998). That was the role we tried to play, creating a healthy and stable triangle.

When making a balance, it makes a lot of sense reading the relational paradox of the suffering couple, suggested by Elkaïm (1998): every spouse acts in such way as to protect the profound schemes of the other spouse, helping him/her not to leave his/her fortress, the armour that protects his/her wounds. Besides, each of them makes a lot not to change his/her beliefs. So, the quoted author translates in this words the message exchanges between the members of the couple: "Si tu m'aimes, ne m'aimes pas. Pourquoi ne m'aimes-tu pas, toi qui prétends m'aimer ? ". Also the therapist, an element of the couple, has the tendency to reinforce those deep beliefs of his /her clients, so he/she doe not disarm them. We avoided doing it.

When we heard on the sixth session the balance of Manuela and Manel, it seemed we were listening to exactly the same thing we had heard on the first session. So, after all this, is it all the same? Meanwhile we notice a detail: now we clearly hear through some dialogue between them, which we only sensed on the first session, through the noise of those vague and inconstant speeches. It is as if, after all, the path was in sight and we only mobilized them so they could "take the sand off their eyes". Really, what we did was to catalyse the communication between them, helping the triangulation with a third: their relationship with the *We*. We tried to meet the appeal they were bringing us of trying to be a couple and a family.

In certain moments we even feared that our messages were moralist and naïve, but quickly the realization that Manel and Manuela were not stuck to their content comforted us, they were only using them as an excuse to live different experiences. Detailing the message served essentially to assure them that what we proposed had a meaning for us (whose specific content was the least important in that situation), as well as, it could start having for them, giving it the meanings that best fitted their personal coherence.

The experience of building a *we*, in an undeniable effort to reinforce the relationship, has lead to question more clearly its viability. The possibilities of communication emerged during the sessions and were not receiving continuity; movements of approach were being consumed in front of us and were not generalized in every day life. Meanwhile, the conflict situation, far from getting worse, was getting softer, seeming to befinit from some calm and security, given by the affection exchanged during the sessions and by the progressive explanation of the situation.

They explored alternatives and we saw each one of them experiment impossible ones, in a self-flexibility, before "unimagined". Manel, sleeping in a separate room,

leaving in a sexual abstinence, accepting the limits imposed by the other; Manuela, confronting herself with her emotions in the emptiness of their arguments, degladiating herself with anguishes and hesitations, without charging Manel's responsibility or idealizing in him the magical key to her well being.

Having these limits before dreaded, everything seemed more bearable and negotiable. They said goodbye without making any decision about continuing the relationship. Each one's position was getting clearer and more differentiated each time. Everything, almost everything, would be possible…

The four of us accomplished a commandment in a couple's process: "the experience of therapy will have to be an experience of growth of each of the spouses" (Sampaio e Gameiro, 1985:108).

Shortly after we had kept our part of the therapeutic contract, we contacted the Paredes, asking for permission to write and publish this text. The receptivity was amazing: of course the answer was yes and, more then that, they wanted to show their satisfaction, for we had thought of them. They would surely read the chapter of the book, even because they thought it could be useful.

Will both of them talk about what is written on these pages? Maybe one day they will answer this question.

References

Andolfi M. (1981) *A Terapia Familiar.* Lisboa, Editorial Vega.

Benoit J. C. et al (1988) *Dictionnaire Clinique des Thérapies Familiales Systémiques.* Paris, ESF.

Brandes D. Phillips H. (1977) *Manual de Jogos Educativos. 104 jogos para professores e animadores de grupo.* Lisboa, Moraes Editores.

Caillé P. (1991) *Un et un font trois. Le couple révéle à lui-même.* Paris, ESF.

Duhl F. S. Duhl B. S. (1979) *Apprentissage, espace et action en thérapie familiale. Les bases de la structure.* In D. Bloch, Techniques de base en thérapie familiale. Paris, Delarge.

Elkaïm M. (1998) *A Família, o indivíduo e as suas redes.* Workshop, ISMT. Coimbra.

Gameiro J. et al (1994) *Quem Sai aos Seus…*Porto, Afrontamento.

Gonçalves O. F. (1989) *Olá… Mhm… Mhm… Adeus… Para uma estética da asserção social.* Porto, Edições Jornal de Psicologia.

IREFREA (1999) *Rapport synthesis: New approaches of prevention and intervention for drug – addicted women in Europe.* Venezia, European Commission.

Lourenço M. C. Henriques M. (2000). *Manel e Manuela ou uma terapia de ex-solteiros*. In A. P. Relvas – "Por Detrás do Espelho. Da teoria à terapia com a família". Coimbra, Quarteto.

Mourão - Ferreira D. (1986) *Um Amor Feliz.* Lisboa, Presença.

Nichols M. Schwartz R. C. (1998) *Family Therapy Concepts and Methods* (fourth edition), Allyn and Bacon.

Prud'homme J.- C. (1981) *La sculpture familiale: technique d'évaluation, de traitement et d'enseignement*. Thérapie Familiale, 2, 147-154.

Rosenbaum A. O'Leary K. D. The treatment of Marital Violence (1986) *In* Jacobson; A. Gurman (eds) *Clinical Handbook of Marital Therapy*. New York, The Guilford Press.

Sampai D. Gameiro J. (1985) *Terapia familiar*. Porto, Afrontamento.

Santos Alarcão Cortesão (1991) *Terapia de Casal.* Coimbra, Curso de Intervenção Sistémica, SPTF. Texto policopiado.

Sluzki C. Cecchin G. (1996) *Prática Sistémica: Desconstrução e construccionismo social na prática clínica.* Workshop, SPTF. Porto.

LINKS

- European Commission DG Health & Consumer Protection website**:** **http://europa.eu.int/comm/dgs/health_consumer/**
  The General Directorate is promoting actions on Public Health and drug prevention.

- ERIT**: http://www.erit.org**
  European federation of national associations of professionals. There is a good list of links to others web pages.

- SOCIDROGALCOHOL**: http://www.socidrogalcohol.org**
  Spanish association of professionals working in addictions. There are summaries of the papers appeared in their scientific journal Adicciones

- NIDA**: http://www.nida.nih.gov**
  The National Institute on Drug Abuse is the governmental American agency on drugs financing most of the research in the USA. It is possible to download many interesting books on line.

- PLAN NACIONAL SOBRE DROGAS**: http://www.mir.es/pnd**
  It's the Spanish governmental agency dealing with the drug problems. It is possible to do searches on line in their data base.

- FUNDACION DE AYUDA CONTRA LA DROGADICCION**: http://www.fad.es**
  This is a Spanish foundation specialised in prevention. It is possible to do searches on line in their data base.

- IDEA PREVENCION**: http://www.idea-prevencion.com**
  Specialised in gathering information on prevention programs. It is possible to do searches on line.

- INSTITUTO PARA EL ESTUDIO DE LAS ADICCIONES**:** **http://www.ieanet.com**
  Important web site in spanish on addiction. A lot of links to other web sites on addiction.

- EMCDDA**: http://www.emcdda.org**
  The Emcdda is the european official agency on addictions. It is possible to have access to official documents and to download reports and books.

- UNDCP**: http://www.undcp.org**
  United Nations web site on drug policy.

- ALCOWEB**: http://www.alcoweb.com**
  Web site specialised on alcohol.

- European Working Group on Drugs Oriented Research: **http://www.stir.ac.uk/Departments/HumanSciences/AppSocSci/DRUGS/ewodor.HTM**

- Mission Interministérielle de Lutte contre la Drogue et la Toxicomanie**: (MILDT): www.drogues.gouv.fr**

- Archives for Drug Literature: http://www.archido.de

- Substance Abuse Resource Center: **http://substanceabuse.rwjf.org**

This book and other IREFREA books can be downloaded in
www.irefrea.org

IREFREA

IREFREA is a european network interested in the promotion and research of primary prevention of different sorts of juvenile malaise and the study of associated protective and risk factors.